

Assessing Nutritional Risk

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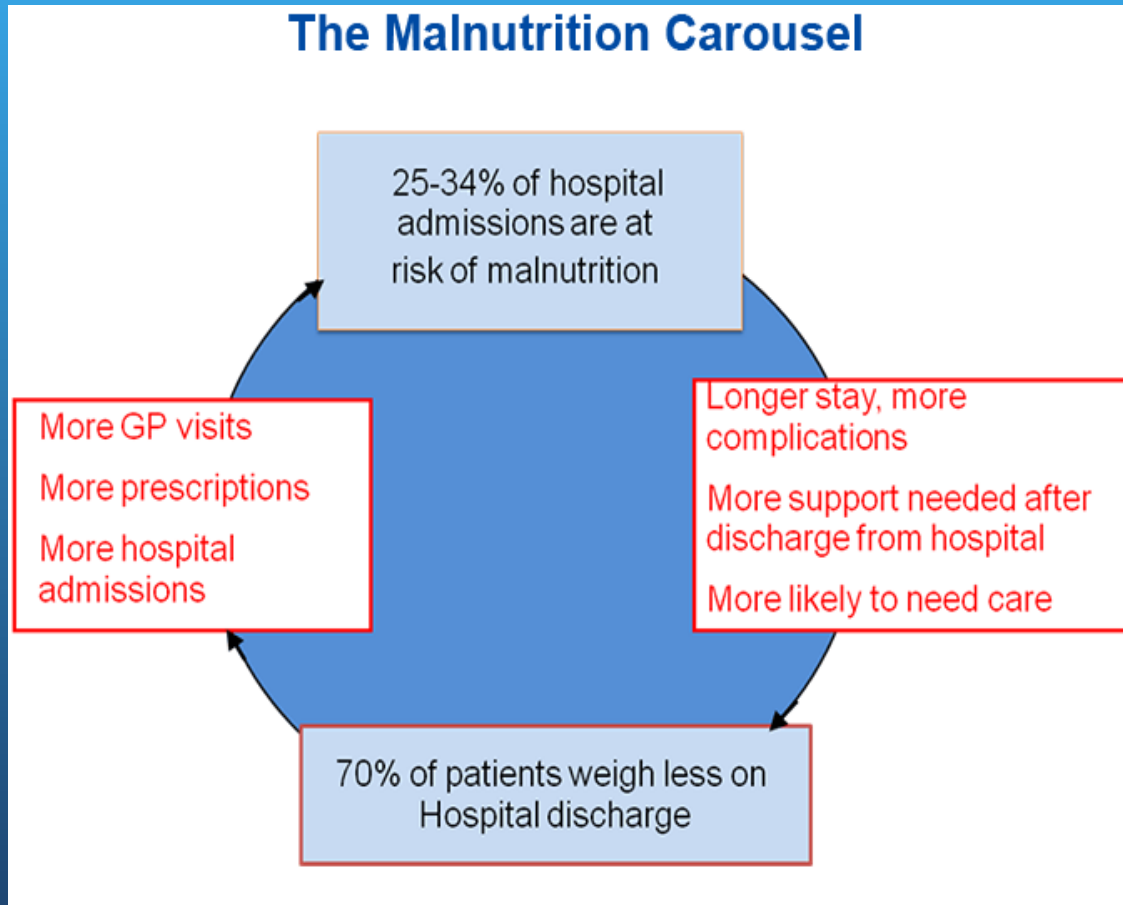
Aims

- Why we assess nutritional risk.
- The symptoms of malnutrition
- Barriers to improved nutrition
- How we assess nutritional risk.
- How to use nutritional screening to help patients.
- Signposting.
- Case study.

Why do we assess nutritional risk

- To identify patients at risk of malnutrition or who are already malnourished.
- Malnourishment = A state of nutrition in which an imbalance of energy, protein, and other nutrients causes measurable adverse effects on tissue / body form and function and clinical outcome. (BAPEN 2016)
- Malnutrition is a term that can be applied to people who are undernourished and also over nourished.
- When we complete nutritional screening we are trying to identify people at risk of undernourishment.

Why the concern....



The Symptoms of Malnutrition

- Little or no appetite
- Weight loss - clothes too large, dentures too big, rings/ jewellery too big.
- Low energy and feeling tired.
- Poor Concentration
- Unable to perform normal tasks
- Altered mood
- Reduced physical ability.

Barriers to improved nutrition

Dentures too big Unable to chew effectively	Addiction to drugs or alcohol Skipping meals
Sore mouth Oral thrush Dentures rubbing Head and neck illness	Unable to prepare food Physical barrier Lack of knowledge Lack of motivation Unsafe due to dementia
Unable to physically feed themselves Broken arms Unable sit up Cognitive barrier	Unable to access the shops Isolation No longer able to use public transport
Loss of smell and taste Due to drugs or disease	Depression Mental health illness Loss of spouse Lack of motivation Loneliness
Unable to swallow safely Maybe temporary or long standing	Restrictive Diets Lack of knowledge Reduced availability in hospital Preference for home cooked meals

Identifying patients at risk of Malnutrition

- Nutritional screening should be completed on all adult patients within 24 hours of admission to hospital.
- The Malnutrition Universal Screening tool (MUST) is used to assess adults at New Cross Hospital.
- The tool is now electronic and recorded via the Vitalpac programme.
- Vitalpac will store MUST scores from the current admission and make comparisons to previous admissions in the last 3-6 months.
- The assessment should be completed by a Nurse.

MUST

- Assesses patients at either a Low, Medium or High risk of malnutrition over 3 steps. Each step is scored.

STEP 1	STEP 2	STEP 3
Body Mass Index (BMI) score.	Unintentional weight loss over the last 3 -6 months.	Acute disease effect score



BMI kg/m ²	Score
>20	0
18.5-20	1
<18.5	2

+

%	Score
<5	0
5-10	1
>10	2

+

Acutely ill and there has been or is unlikely to be no nutrition for the next 5 days = score 2

STEP 1 - BMI

- Uses a patients height and weight.
- All patients need to be weighed
 - Standing scales
 - Seated scales
 - Hoist scales
 - Bed Scales - Medical equipment library.

If the equipment is not available then Mid upper arm circumference (MUAC) can be calculated by a trained nurse.

If your ward needs MUAC training speak to your ward dietitian.

STEP 1 BMI - Continued

- Height - Standing if possible.
- Otherwise heights can be estimated using ulnar length
- Measure between the elbow point (olecranon process) and prominent bone of the wrist (styloid process).
- Left side if possible.
- When entering the data into vitalpac ... either kg/stones or feet/meters is possible but make sure you've put them in the right box... or we get BMI's of 2.0kg/m²



STEP 2 - Weight loss

- Unplanned weight loss in the last 3 - 6 months.
- Can be input manually to Vitalpac.
- Vitalpac also looks at previous admissions in last 3-6 months and calculates weight loss in that time.
- If weights are incorrect from previous admissions this may generate a false MUST 2 for weight loss.
- If you calculate a MUST incorrectly... human error... it is possible to strike through that entry so that it is not used. (needs to be done by ward Vitalpac administrator)

STEP 3 - Acute disease effect

- Either a score of 2 or 0

Given if the patient is acutely ill and...

Has had no or very little nutrition for the last five days.
Remember.... This may be prior to admission as well..

Or is likely to have little or no nutrition for the next five days.

STEP 4 - Overall Risk

Add the scores from step 1,2 AND 3 together.

SCORE 0 = Low risk of Malnutrition

SCORE 1 = Medium Risk of Malnutrition

SCORE 2 or >2 = High Risk of Malnutrition

STEP 5 - Risk Management

- MUST 2 or more

Refer to the dietitian

How - Via the ward teletracking board

Whilst waiting... Keep accurate food charts including amounts eaten.

Dietitian should assess within 48 hours of referral.

If a patient is requiring and enteral feed / parenteral nutrition please also call ext 5335 and let the dietitian know.

STEP 5 -Risk Management

- MUST 1
- Start a nutritional care plan
- Strict food record charts - include amounts eaten.
- Ward snacks, milky drinks, snacks from family.
- For dementia patients - Would finger foods help? Does the patient need assistance at meal times? Do they manage better with different food consistencies? Is a large meal off putting?

STEP5 - Risk Management

- SCORE = 0
- Repeat MUST score in 1 weeks time.
- If in care home to monitor MUST monthly, community patients at risk, MUST should be monitored annually.

Inpatient Referrals

	Referred	In Progress	Complete	Delay Reason	Notes	Last Updated
artificial nutrition support (for PN bleep 7137)				Select...	<input type="text"/>	
MUST 2 or more				Select...	<input type="text"/>	22/02/2016 09:47
Dietary Education				Select...	<input type="text"/>	
ONS Review				Select...	<input type="text"/>	

Save Save and Close Close

- Artificial Nutrition Support = NG, NJ, PEG, RIG, Jej (also call 5335)
- Must of 2 or more - As it says.
- Dietary Education - Low potassium, Low phosphate, Diabetes education, Pressure damage, IBD, Coeliac advice, low residue diet, no added salt diet.
- ONS review - Means Oral Nutritional Supplements = If the patient has been admitted with supplements (Fortisip/Fortijuce/Ensure) already prescribed in the community

Signposting

- Know your ward dietitian... ask for their bleep number
- Dietitians office is extension 5335
- We live in Building 12 (behind the WMI)
- Referrals via Safehands only unless the patient is referred for parenteral nutrition or enteral nutrition (after 9am).
- Outpatient referrals - Via GP or health professionals - letter or fax.

CASE STUDY

- Jessie is a 75 year old lady who was admitted this morning after a fall at home. She has fractured her hip and will require an operation. You are completing her MUST screening. She reports her height is 5ft 2 inches and you have weighed her using the bed scales, she is 45kg. Vitalpac tells you that since her last admission 4 months ago she has lost 13.5% of her body weight. She tells you that her clothes feel bigger. You saw her eat $\frac{1}{2}$ of her lunch and she has just eaten some biscuits and a cup of tea.
- What is Jessie's MUST Score?
- What action should you take next?

Case Study

- Mr Patel was admitted 7 days ago. His MUST score on admission was 0. Two days into his admission the Dr's diagnosed him with Sepsis. He has been very drowsy and you can see that he declined 2 meals yesterday and ate only spoonful of his meals for the last 4 days. When you weigh him you can see that he has lost 2.9% of his body weight since admission. His BMI is now 22.7kg/m².
- What is this patients MUST score now?
- What should you do?