ARE YOUR PATIENTS STARVING? NUTRITION IN PATIENT CARE

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Thoughts of malnourished poorly people with emaciated limbs conjure up images of African droughts or pre-war TB isolation hospitals, not NHS hospital wards in the 1990s. Yet published surveys regularly report on the surprisingly high incidence of malnutrition in surgical patients⁽¹⁾ medical wards⁽²⁾ and on wards for the elderly⁽³⁾. A quarter of children with chronic respiratory or cardiac disorders and even more with digestive disorders are shorter than most children of their age⁽⁴⁾.

So why does it matter and what can you do about it? First of all, in the short term nutritional status affects patients' wellbeing and outcome^(1,3,5) and weight loss is a major cause of concern for patients, particularly those with cancer⁽⁶⁾. Secondly, what we eat now has a profound effect on our longterm health⁽⁷⁾. We will return to this in a later article. In the meantime, I will consider why we need to identify those at risk of malnutrition and how it occurs, together with what action we can take to deal with it.

It is vital to identify those at risk of malnutrition because it causes:

- Apathy and depression (leading to the loss of morale and will for recovery)
- Weakness and tiredness (further reducing ability to eat)
- Respiratory muscle weakness (increasing risk of chest infection^(8,9))
- Reduced cardiac muscle function⁽¹⁰⁾
- Reduced mobility (delaying recovery⁽¹¹⁾ and predisposing to thrombo-embolism and pressure sores⁽¹²⁾)
- Impaired immune response to infection (which in turn further worsens the nutritional status⁽¹³⁾)
- Altered structure and function of gut and increased liability to entry and spread of intestinal bacteria within the body⁽¹⁴⁾.

Starvation is thus an insidious factor which delays recovery, increases the need for high dependency nursing care and sometimes intensive care, increases the risk of serious complications of illness, and at its worst leads to death either from an unnecessary complication or from inanition. In economic terms, the hospital admission of a malnourished patient costs more than one whose nutrition is maintained⁽¹⁵⁾. It has been estimated that at least £266 million could be saved annually in Britain taking into account the cost of nutrients and increased nursing time for their administration^(16,17).

Malnutrition is caused by many factors including:

- Lack of knowledge of staff. Two surveys, one in Scotland⁽¹⁸⁾ and the other in England⁽¹⁹⁾ showed that senior medical students were only able to answer correctly half of a number of factual questions on nutrition topics. Until recently clinical nutrition was not included in undergraduate medical schools. Teaching has lagged behind nutritional research which has forged ahead^(20,21)
- Poor appetite (due to illness and/or treatment)
- Inability to eat, chew or swallow
- Malabsorption – due to illness or surgical intervention (especially of gut)
- Small stomach syndrome (following gastrectomy)
- Increase in requirements e.g. for energy (calories) to aid recovery
- Illness itself e.g. cancer, multiple sclerosis
- Unsuitability of food
- Lack of nursing supervision at meals because no-one notices that a patient isn't eating
- Frequent hospital tests and "nil by mouth" regimes

Control of these factors is by different groups of professionals i.e. doctors, nursing, catering staff and dietitians, so all need to be included in any attempts to develop local policies.

So what can we do to reduce the risk and effects of malnutrition in our patients? The King's Fund Report 'Nutrition as Positive Treatment'⁽¹⁵⁾ suggests:-

- 1 Encouraging all staff, including doctors, nurses, caterers and dietitians, in the hospitals and community, to take responsibility for nutrition. It is not just the remit of the dietitians. We need to consider establishing a Nutrition Steering Group locally as recommended by the British Association for Parenteral & Enteral Nutrition⁽²²⁾.
- 2 Regularly updating medical and nursing staff in the hospital and community (in NHS and private sector) on nutrition.
- 3 Assessing nutritional status of all patients on admission and regularly thereafter if illness or recovery is prolonged. The assessment should include questions about:-

- normal and present weight
 - recent changes in body weight
 - ability to swallow, chew etc
 - food intake
 - appetite
 - activity and energy levels
- and should include a physical examination.

- 4 Ensure that suitable acceptable food and snacks are available for all patients.
- 5 Ensure that a range of nutritional supplements are available for all patients on the wards and at home. There is concern about the growing prescribing costs of nutritional supplements in the community. We need to be able to show that the cost of providing them is less than providing care for the treatment of malnutrition and its complications.
- 6 Provide up-to-date, accurate, consistent dietary advice, designed to meet individuals' needs and circumstances.
- 7 Monitor and audit the effect of providing nutritional support i.e. the effect it has on patient outcome.

Locally we have made some progress towards implementing these recommendations:

- 1 Two years ago, using Regional audit monies, the dietitians developed a Nutritional Assessment Tool which is now being used routinely within the Medical Directorate. We would like to see this used throughout the Acute Trust.
- 2 There is an ongoing input on Nutritional Support on P2000 and degree nurse training locally and regular updates for Community Nurses.
- 3 A Nutrition Link nurse scheme has been developed within the Royal Lancaster Infirmary and a training package for junior medical staff is to be launched in September this year.

What I feel we need to develop next is a Nutrition Steering Team to develop a multidisciplinary approach to nutrition which is recognised by all, and audit tools and indicators of outcome.

CONCLUSION

We can see that malnutrition is a problem (or a challenge?) in our midst and if we want to reduce its effects and improve patient wellbeing, we all need to become more proactive in its prevention, detection and treatment and we need constructively to audit our efforts⁽¹⁵⁾.

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