The Identification, Treatment and Management of Malnutrition in Adults, Including the Appropriate Prescription of Oral Nutrition Supplements

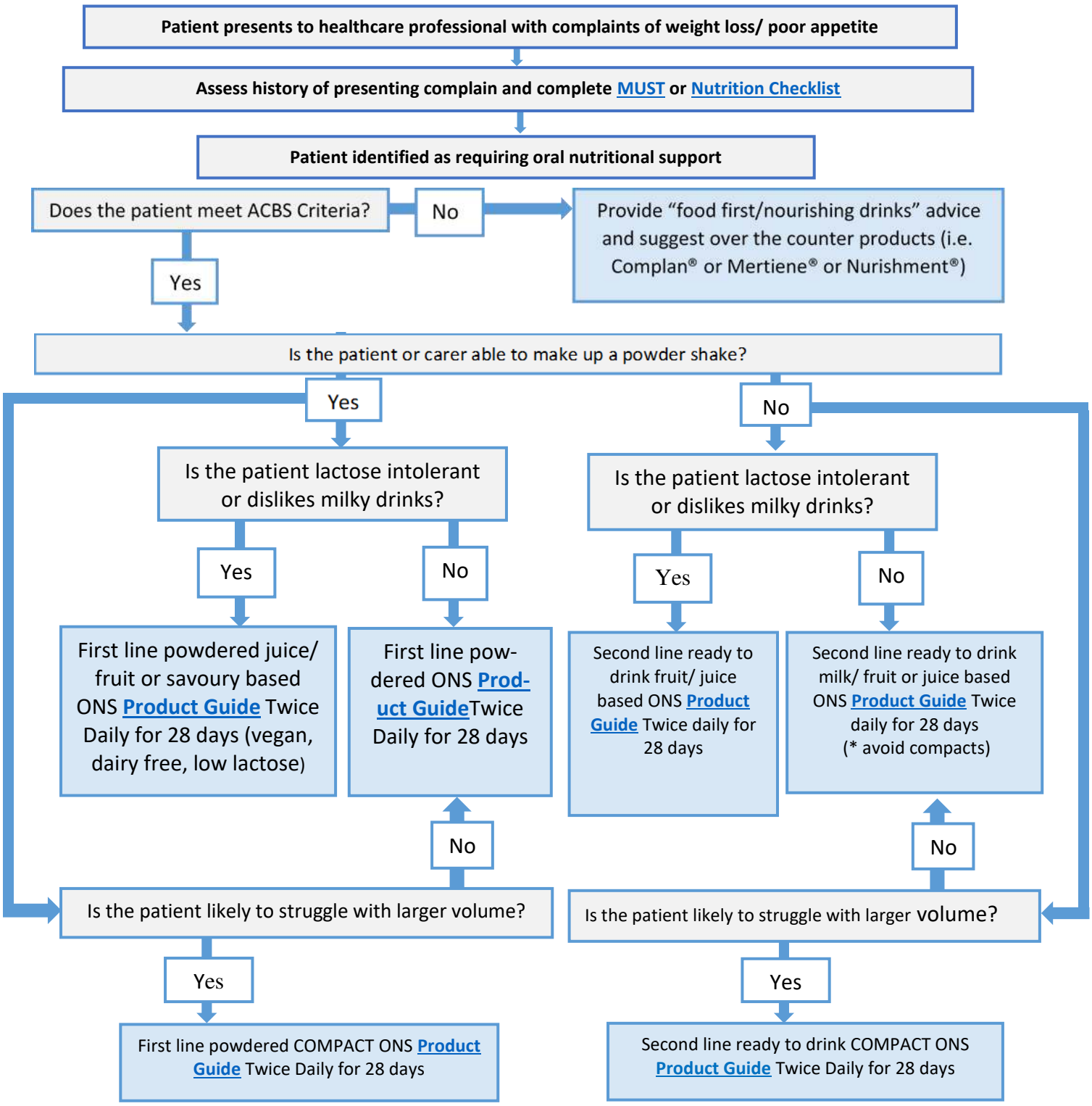
Summary: These guidelines aim to improve the identification, treatment and management of malnutrition with a focus on adult community-dwelling patients and those residing in care homes. The guidelines should be implemented to promote and facilitate standardised evidenced-based practice including the appropriate use of oral nutrition supplements (ONS).

Approval date: March 2022 **Review date:** March 2024 **(or sooner if evidence or practice changes)**

South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London: South East London Clinical Commissioning Group (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

Section 1

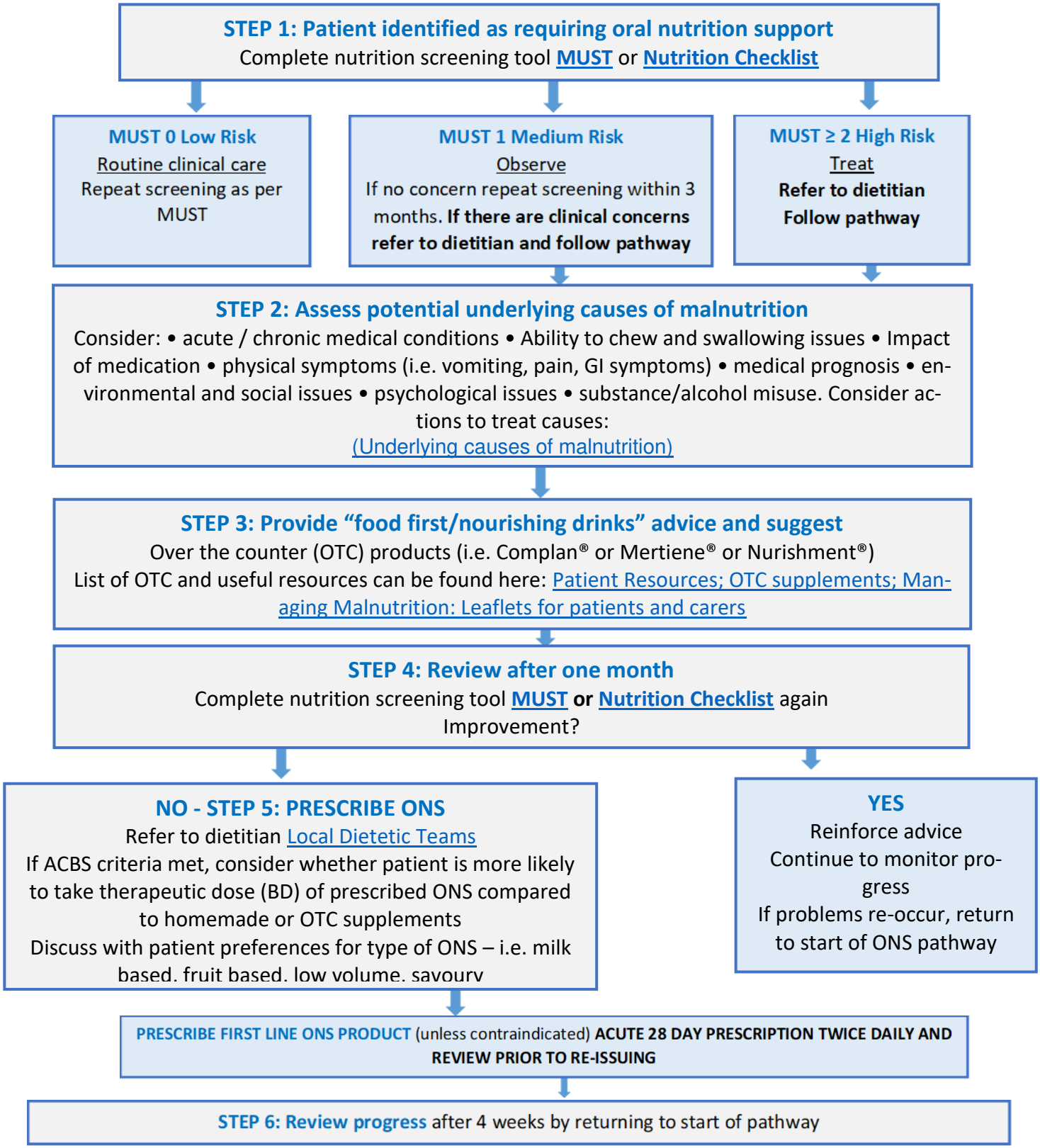
1.1 Oral nutritional supplements (ONS) prescribing algorithm for primary care clinicians



Advisory Committee on Borderline Substances (ACBS) Indicators (BNF, 2019)

Disease Related Malnutrition, Short Bowel Syndrome, Intractable malabsorption, CAPD, Haemodialysis, Following total gastrectomy, Intractable malabsorption, Proven inflammatory bowel disease, Pre-operative preparation of undernourished patients, Dysphagia, Bowel Fistulas

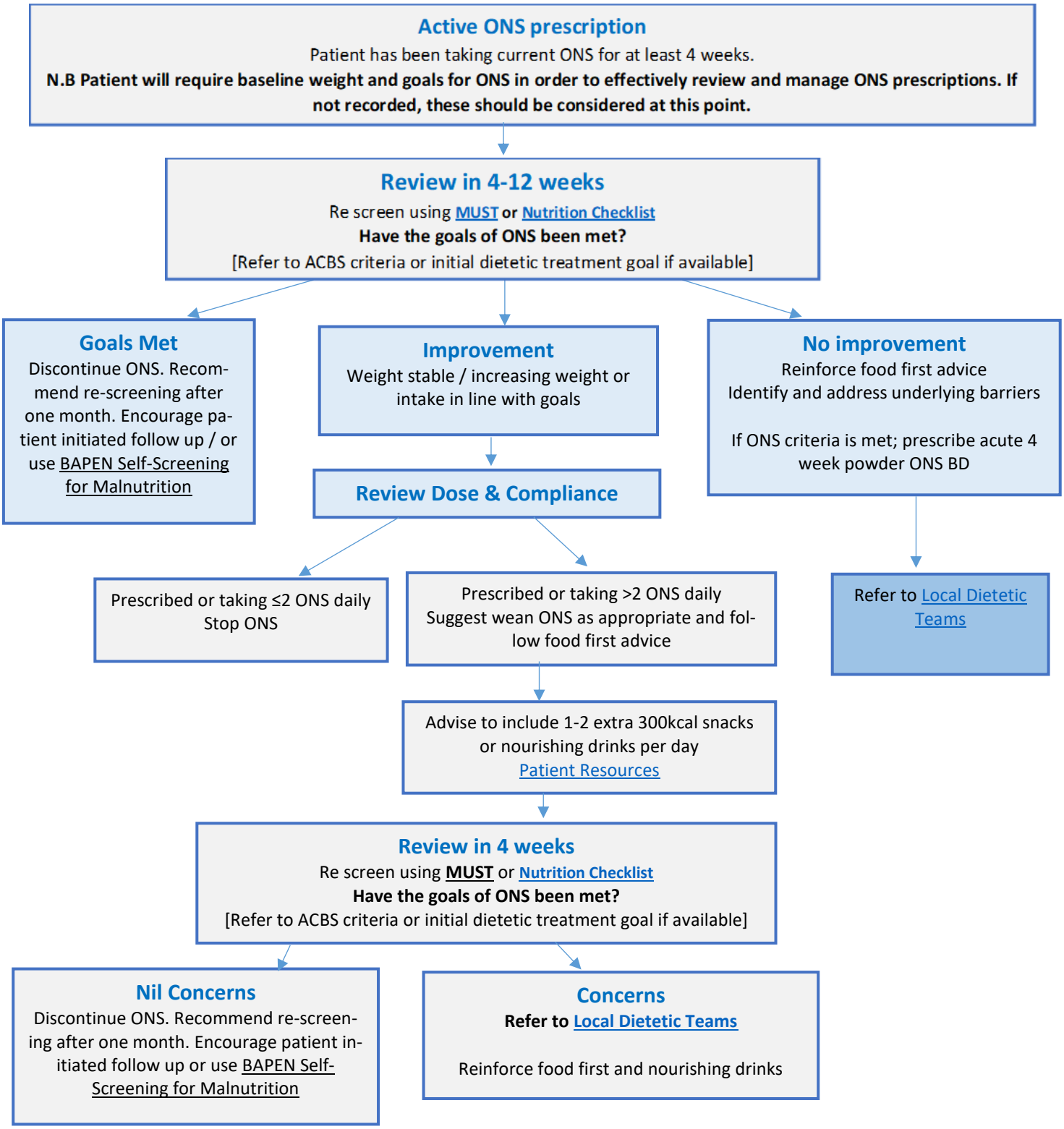
1.2 Primary care clinician pathway for assessing and managing malnutrition risk



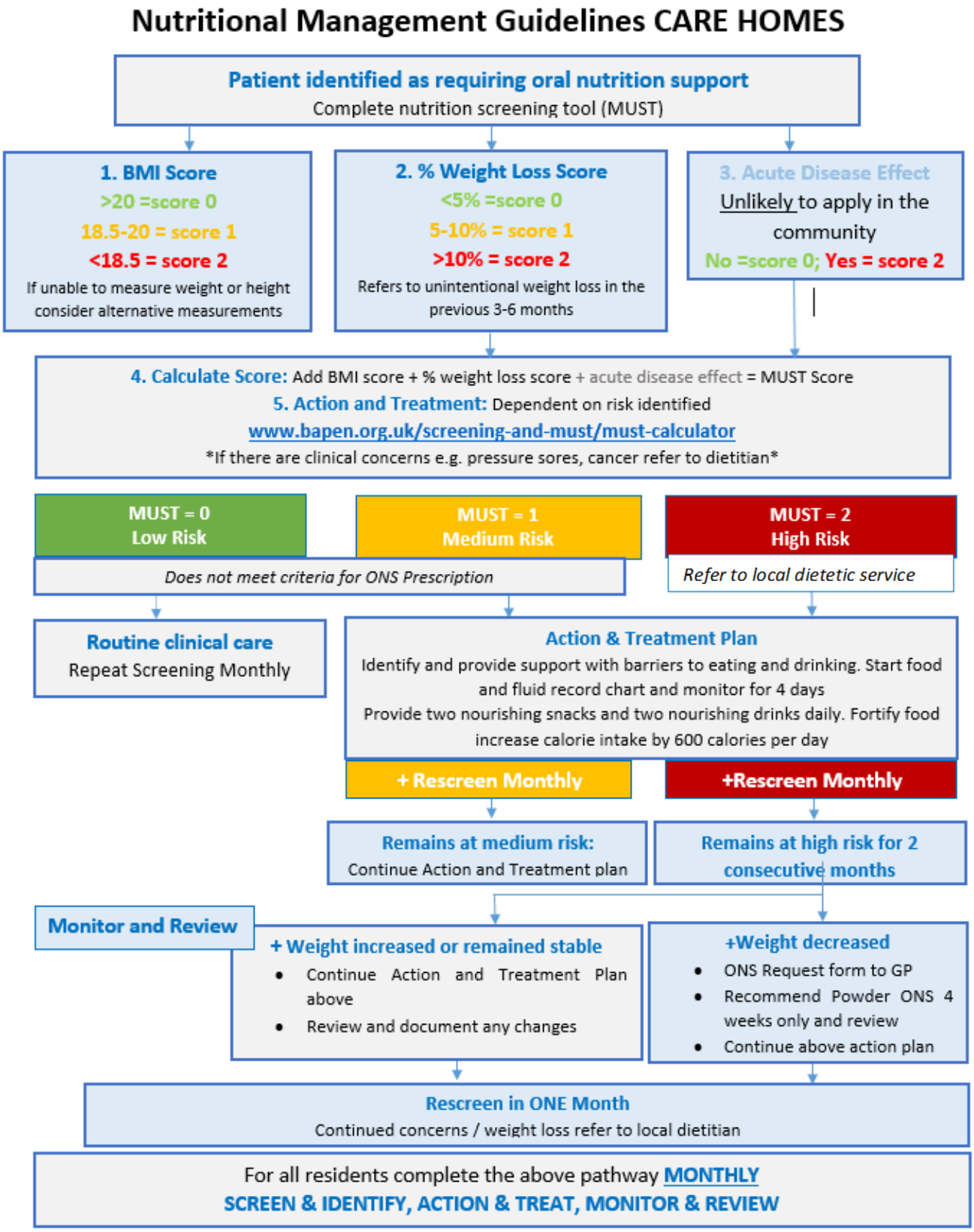
GP QUICK REFERENCE GUIDE FOR PRESCRIBING ONS Product Guide

1.3 Primary care clinician algorithm for reviewing and discontinuing ONS

Patients on ONS should be reviewed regularly ideally every 3 months to assess progress towards goal and whether there is a continued need for ONS prescription. Below references how to review and discontinue ONS prescriptions for patients **not under dietetics** or **who have been discharged from dietetics on ONS**.



1.4 Nutrition Management Guidelines for Care Homes



1.5 Key Recommendations

- Ideally, ONS should only be prescribed on the advice of a dietitian. If ONS are required before dietetic assessment, ONS should be prescribed with reference to algorithm (1.1) and the patient referred to the appropriate dietetic service.

- If patients are able to take oral diet it is important to encourage high calorie/protein food first before starting supplements. Refer to Patient Resources for food fortification, culturally acceptable foods and the use of over the counter supplements.

- All patients admitted to hospitals, care homes, new patients attending General Practitioner (GP) surgeries, vulnerable individuals or where there is clinical concern (i.e. those who are frail, elderly, poor, socially isolated, severe diseases and disabilities) should be screened using a validated nutrition screening tool e.g. Malnutrition Universal Screening Tool 'MUST' or nutrition screening checklist, Nutrition Checklist

- Realistic and measurable goals should be set when initiating ONS to aid prescribing and guide appropriate discontinuation of ONS. Consideration for disease stage and treatment should be considered e.g. for palliative care or those in advanced stage of illness goals and interventions need to be adjusted accordingly.

- ONS prescriptions should only be ACUTE and include specified flavours.

- Do not prescribe red ONS products, Extended Product Guide these products should only be prescribed following dietetic assessment with clinical justification.

- Prescription request from a hospital / dietetic department that fail to include ACBS criteria, goal of ONS, or indicate why first line products are not suitable should be swapped to community first line products, Product Guide for a maximum of 4 weeks and then stop. If there are nutritional concerns a referral to local community dietetic services is recommended Local Dietetic Teams

- Care or nursing home residents who may require ONS should be referred to the dietitian for a review. Practices should ensure this is actioned and should not prescribe for patients simply on request.

- When conducting general medication reviews ONS should be included.

- Patients identified as requiring long term ONS should have a minimum of an annual review to ensure the prescription is clinically indicated and appropriate.

- If the patient does not meet ACBS criteria, or the patient wishes to continue ONS, over the counter (OTC) nutritional supplements, food first methods and homemade nourishing drinks should be recommended Patient Resources

- Patients who fail to engage or attend two consecutive reviews of ONS the current prescription should be stopped and the patient informed.

1.5 Introduction

These guidelines aim to improve the identification, treatment and management of malnutrition with a focus on adult community-dwelling patients and those residing in care homes. The guidelines should be implemented to promote and facilitate standardised evidenced-based practice with regards to the management of community adult patients who are malnourished or at risk of malnutrition and who require nutrition support, including the use of oral nutrition supplements (ONS). This guidance does not include recommendation for the provision of enteral tube feeding or parenteral nutrition. Advice should be sought from local Home Enteral Feeding teams.

1.6 Scope

These guidelines are intended to provide information and guidance on current best practice, reduce unnecessary expenditure and to ensure a consistent approach to the management of malnutrition across South East London (SEL) as part of the SEL Clinical Commissioning Group (CCG). These guidelines are designed for use by primary care clinicians who may need to initiate ONS prior to a patient being assessed by a dietitian. These guidelines will also provide advice for medicines optimisation teams, district nurses, pharmacists, care home staff and other community health care professionals to aid appropriate review and management of ONS prescriptions. These will also provide advice for acute and community dietitians to aid best practice, ensure prescriptions are appropriate and cost effective in the community setting.

A Prescribing Support Dietetic (PSD) service has been commissioned across SEL. The service is part of the Medicine Optimisation work stream to support primary care teams. The goal is to ensure appropriate prescribing of ONS in line with ACBS prescribing criteria and local guidelines. And, for patients who do meet prescribing criteria that they are prescribed the most clinically appropriate nutrition supplement through providing tailored nutrition advice, optimizing value by taking into consideration supplement cost.

Section 2

2.1 Malnutrition

Malnutrition is both a cause and consequence of poor health primarily occurring due to an inadequate energy intake resulting in weight loss and a depletion of both body fat and muscle.[1] An inadequate intake of macro and micronutrients can over time cause deficiencies with widespread metabolic, functional and physiological effects on the body.[2] Weight loss is usually unintentional and often goes unrecognised until malnutrition starts to significantly impact an individual's health and wellbeing.[3] A lack of awareness and recognition of the different nutrition requirements for vulnerable groups, as well as social norms around thinning and ageing can result in poorly timed identification and treatment of malnutrition, despite it being a largely preventable and treatable condition.[3]

2.2 Causes

The causes and consequences of malnutrition are often interlinked. Someone who is malnourished will be at greater risk of ill health and injury, which in turn may impact nutritional intake and vice versa. The reasons why an individual may become malnourished can vary. Malnutrition in developed countries is unfortunately still more common in situations of poverty and social isolation. Most adult malnutrition is associated with disease.[3] Identifying the primary cause of malnutrition is essential for implementing the most effective treatment.

Medical or Disease-related Risk Factor

Illness or disease can impact nutritional intake, nutrient absorption and nutritional requirements. A poor appetite causing reduced dietary intake may result from changes in the level of cytokines, glucocorticoids, insulin and insulin-like growth factors.[4] Diseases which affect the gastro-intestinal (GI) tract (i.e. Crohn's disease or GI cancer) may result in reduced absorption or increased losses of nutrients despite adequate oral intake.[4] Illnesses such cancer, infections or burns may increase nutrition requirements making it difficult for patients to consume an adequate diet. Long-term conditions such as dementia or chronic obstructive pulmonary disease (COPD), as well as mechanical problems such as dysphagia or reduced gastric capacity may make eating more difficult. Psychological impacts such as depression, anxiety, social isolation, loneliness or a lack of motivation can impact dietary intake.

Physical Risk Factor

Inadequate nutritional intake may result from physical or disability-related risk factors. Poor dentition may make eating difficult and painful. Physical injury or pain may impact an individual's appetite or impact their ability to feed themselves. Reduced mobility may affect an individual's ability to access and prepare food independently.

Social Risk Factor

Social risk factors contributing to malnutrition are complex and can be difficult to manage. Low income can result in food insecurity and living conditions which have limited resources for food preparation.

Groups at risk of malnutrition[4]	
Chronic Diseases	COPD, cancer, inflammatory bowel disease, renal or liver disease
Progressive neurological diseases	Dementia, neurological conditions (such as Parkinson's disease and motor neuron disease)
Acute Illness	Where food is not being consumed for more than 5 days (this is often seen in the acute setting and is rare in the community)
Debility	Frailty, immobility, old age, depression, recent discharge from hospital
Social Issues	Poor support, housebound, inability to cook and shop, poverty
Rehabilitation	After stroke, injury, cancer treatment
Palliative Care	Tailor and adjust advice according to phase of illness

2.3 Prevalence

Malnutrition is estimated to affect at least three million adults in the UK.[, 5, 6] It is estimated that 1 in 10 people over the age of 65 are malnourished or at risk of malnutrition.[7] It is estimated that ~93% of individuals who are malnourished or at risk of malnutrition are community-dwelling, 5% reside in care homes, 2-3% in sheltered accommodation and 2% are in hospital.[5, 8]

2.4 Impact

Patient

Malnutrition is directly associated with delayed recovery, increased complications and increased mortality.[9] Adverse effects to the individual include:

Adverse effects of malnutrition[10,11,12]
• Impaired immune responses – increasing risk of infection • Reduced muscle strength and fatigue – reduced ability to perform tasks of daily living • Reduced respiratory muscle function – increasing risk of chest infections and respiratory failure • Impaired thermoregulation – predisposition to hypothermia • Impaired wound healing and delayed recovery from illness • Apathy, depression and self-neglect • Impacts on quality of life and wellbeing • Increased risk of admission to hospital and length of stay • Poor libido, fertility, pregnancy outcome and mother child interactions

Healthcare System

Malnutrition is associated with increased mortality and morbidity and results in a greater use of healthcare resources. Malnourished individuals have two times more GP consultations, three times more hospital admissions, once admitted an average of three-day longer hospital stay, require increased post-discharge support, have increased prescription costs and experience delayed discharge from hospital. [9]

Financial

The estimated annual health costs associated with malnutrition exceed £19.6 billion annually and more than 15% of the total expenditure on health and social care.[6,9] Most of these costs are associated with hospital care (78%) rather than social care (22%) with the costs dominated by secondary care rather than primary care.[10] The cost of treating malnourished individuals is two to three times greater than that of a non-malnourished individual.[9] Effective strategies to prevent, improve the identification and treatment of malnutrition have been estimated to have the third highest potential to deliver cost savings to the NHS.[10]

Section 3

3.1 Screening, Identification and Management of Malnutrition Risk

All patients admitted to hospitals and care homes, new patients attending General Practitioner (GP) surgeries, vulnerable individuals or where there is clinical concern (i.e. those who are frail, elderly, poor, socially isolated, severe diseases and disabilities) should be screened using a validated nutrition screening tool e.g. Malnutrition Universal Screening Tool 'MUST[11]. MUST is a 5 step validated screening tool, used across acute and community healthcare settings to identify an individual's risk of malnutrition, categorised as low, medium or high. Screening should be repeated at regular intervals and the same tool should be used when individuals move from one healthcare setting to another.[11]

When measurements of height, weight and Body Mass Index (BMI) cannot be obtained to utilise a nutrition screening tool, subjective measures should be considered. (Nutrition Checklist) has been adapted from the 4-question Patients Association Malnutrition Checklist tool which can help you to identify patients at risk without objective measures.

Once identified, for community dwelling patients follow the primary care clinician pathway for assessing and managing malnutrition risk (1.2). For patients residing in Care Homes refer to nutritional management guidelines for care homes (1.3).

3.2 Nutrition Assessment and Monitoring

For individuals who fall within all malnutrition risk categories (low, medium and high) the appropriate treatment, management and monitoring guidelines should be followed on completion of screening.

Low Risk (MUST score 0)	Medium Risk (MUST score 1)	High Risk (MUST ≥ 2)
Routine clinical care 1. Repeat screening: -Hospital: Weekly -Care homes: Monthly -Community: Annually	**Observe** 1. Document dietary intake for 3 days 2. If adequate or little concern then repeat screening: -Hospital: Weekly -Care home: Monthly -Community: at least every 2-3 months 3. If inadequate – clinical concern, follow local guidance (refer section 1.2)	**Treat** 1. Refer to Dietitian (Local Dietetic Teams) 2. Follow local guidance (refer to section 1.2) 3. Monitor and review: -Hospital: Weekly -Care home: Monthly -Community: Monthly

Note, step 3 of the MUST tool assigns a score for 'acute disease effect'; *"If the patient is acutely ill **AND** there has been or is likely to be no nutritional intake for 5 days".* The British Association for Parenteral and Enteral Nutrition (BAPEN) recommend the acute disease effect is unlikely to apply to patients outside of hospital.

Once nutritional risk has been established, the underlying cause of malnutrition should be assessed (Underlying causes of malnutrition) and treatment options identified. In addition to medical and pathological reasons, including disease related malnutrition; social and psychological reasons for increased malnutrition risk should be considered. The MUST is a nutrition screening tool only, and therefore may not identify/capture clinical indicators of poor nutritional

status in all patients. If concerns are present regarding poor nutritional intake, absorption or losses, a local dietetic referral should be completed in order for patients to receive a full nutritional assessment and advice regarding an appropriate treatment and management plan.

3.3 Treatment

Food First

The prevention and treatment of malnutrition requires an individual to consume adequate calories (energy), protein and micronutrients. Depending on the underlying cause of malnutrition this can be achieved through increasing dietary intake. Specific foods and fluids which are naturally high in energy are recommended to stop further weight loss and replete body mass. On completion of nutrition screening and nutrition assessment, education and encouragement to improve nutritional intake through the consumption of high-energy, high-protein foods and fluids should be provided. Oral nutritional supplements (ONS) should not be used as first line treatment. Strategies to tackle social issues or psychological barriers to nutritional intake should also be implemented (i.e. referral to food banks, social services).

Food Fortification and Nourishing Drinks

Initial education regarding the types of foods which are high in energy and protein should be provided. Standard diet sheets and leaflets to support this information can be provided and a range of reproducible diet sheets and materials are available to download and print.

When individuals have a poor appetite, poor dentition or are unable to manage appropriate portions, strategies for food fortification to help improve energy intake without increasing portion size should be provided. Choosing fluids which contain some nutrition, such as full fat milky drinks (malted drinks, hot chocolate, milky coffee, smoothies and milkshakes) or sugary drinks (fruit juice, squash or fizzy drinks) should be prioritised. Additional strategies for increasing dietary intake with a poor appetite should also be provided (i.e. small, frequent meals and snacks).

In the care home setting providing fortified foods and snacks and preparing homemade milkshakes and smoothies for residents should be the cornerstone of nutritional management. To support staff food fortification protocols and care plans can be inserted into the individuals care plan to provide instructions.

Patient Resources provide resources to support clinicians providing patients and carers with advice regarding food first protocols, homemade nourishing drinks and overcoming barriers to nutritional intake.

Oral Nutrition Supplements

Oral nutritional supplements (ONS) should NOT be used as first line treatment. ONS are commercially produced products that have been approved by the Advisory Committee on Borderline Substances (ACBS) as Nutritional Borderline Substances (NBS) and can be prescribed on a FP10 prescription.[2a] These products are included in the British National Formulary, ONS are often prescribed to improve nutritional status and treat malnutrition, and have good clinical outcomes when used appropriately. Whilst ONS have beneficial effects in terms of clinical outcomes, their use as a first line treatment option has caused concerns about efficacy and expense.[2] Food first methods and homemade nourishing drinks should be provided and trialled for **at least four weeks** prior to initiating ONS.

Section 4

4.1 Appropriate Prescribing of ONS

- Oral Nutritional Supplements (ONS) should only be prescribed to patients who **meet ALL the below criteria:**

  1. Have been screened using a validated malnutrition screening tool e.g. 'Malnutrition Universal Screening Tool' MUST and deemed to be at high risk of malnutrition or malnourished (MUST≥ 2)
  2. Assessed regarding the (Underlying causes of malnutrition) with appropriate advice and support to address the underlying cause
  3. Meet the Advisory Committee for Borderline Substances (ACBS) criteria (see below)
  4. Trialled with food first and homemade nourishing drinks, prior to initiating the ONS prescription

- If the patient meets the above criteria, the **ONS Product Guidance** (see section 5.1) should be utilised to ensure a clinically and cost-effective product is prescribed.

ACBS Indications for Oral Nutrition Supplements[20]	
Short Bowel Syndrome	Proven inflammatory bowel disease
Intractable malabsorption	Following total gastrectomy
Pre-operative preparation of patients who are undernourished	Dysphagia
Disease-related malnutrition	Bowel Fistulas
Continuous ambulatory peritoneal dialysis (CAPD)	Haemodialysis

Recommendations:
• If the patient does not meet ACBS criteria, over the counter (OTC) nutrition supplements, food first methods and homemade nourishing drinks should be recommended Patient Resources

4.2 Commencing an ONS Prescription

The standardised **ONS product guidance** provides guidance on clinically appropriate and cost-effective ONS to prescribe. To commence ONS the following steps should be taken:

- Avoid prescriptions for ONS once daily, these provide 300-380kcal per day which can be easily achieved via food first (e.g. snacks) and homemade nourishing drinks (e.g. milky drinks); Patient Resources
- It is rarely necessary to prescribe more than two bottles of nutritionally complete supplements per day. Anyone who is reliant on ONS as a sole source of nutrition or achieves the majority of their nutritional intake from ONS should be under the care of a dietitian.

- Ensure the **patient has trialled the ONS products and different flavours** prior to recommending the prescription aiming to increase compliance.
- The nutritional care plan and goals of using oral nutritional supplements should be clearly documented and agreed with patients. The aim of nutritional support, ACBS indication, timescales for intervention and review, and who is responsible for reviewing the ONS (GP, Dietitian) should be documented and communicated clearly.

Recommendations:

• Goals should be realistic and measurable. When setting a goal consider disease stage and treatment, e.g. for palliative care or those in advanced stages of illness, goals and interventions need to be adjusted accordingly.
  ○ Target weight, target weight gain or target BMI over a period of time
  ○ Weight maintenance where weight gain is unrealistic or undesirable
  ○ Reduced rate of weight loss where weight maintenance is not realistic (e.g. cancer cachexia, end of life care)
  ○ Optimising nutritional intake during acute illness
  ○ Wound healing if relevant

4.3 Reviewing an ONS Prescription

The aim of nutritional intervention or treatment goal, taste preference and a nutritional review plan should have been identified prior to commencing an ONS prescription.

It would strongly be advised, when ONS is initiated for the first time, the preferable ONS should be prescribed on **an acute 4 week** prescription and reviewed by the requesting clinician prior to re-issuing to ensure the patient is tolerating and complaint with the initial product choice. Patients on ONS should be reviewed regularly ideally every 3 months to assess progress towards goals and whether there is a continued need for the prescription (section 1.3). The patient should be rescreened for malnutrition risk following the acute prescription and the management planned altered accordingly (section1.2).

ONS should be prescribed, similar to other medications, on an individual named patient basis and documented in the patients' EMIS/Vision prescription list and record. Some ONS products maybe contraindicated for specific clinical conditions. Therefore, like any prescribed medication ONS **must not** be provided to a patient if they have not been prescribed the product.

Patients prescribed ONS should be reviewed regularly (section 1.3) to assess their progress towards dietetic goals and whether there is a continued need for ONS on an NHS prescription. This should be carried out by a dietitian or suitable healthcare professional, guidance on reviewing ONS prescription can be found in (section1.3).

Recommendations:
• Avoid adding prescriptions for ONS to the repeat template unless a short review date is included to ensure review against goals (as per recommendation box above). • When conducting general medication reviews, ONS should be included as above. • The following parameters should be considered in review (full guidance section 1.3) - Weight / BMI / wound healing depending on goal set - Changes in dietary intake - Compliance and tolerance to prescribed ONS - Stock levels at home / care home • Patients who are identified as requiring long-term/ lifelong ONS should have a minimum of an annual review to ensure the ongoing prescription is both indicated and continues to meet nutritional needs.

4.4 Discontinuing an ONS Prescription

When then the patient no longer meets ONS prescribing criteria/or is identified as not being at risk of malnutrition ONS should be discontinued. Often the reviewing dietitian will communicate to the GP when this may be. If a patient has been discharged from dietetic follow up, the use of ONS should be reviewed and discontinued appropriately by the GP and/ or appropriate primary care clinician (section 1.3). On discontinuing ONS, a patient's risk of malnutrition should be reviewed by completing malnutrition screening within one month, to ensure there is no precipitating problem. Thereafter, routine malnutrition screening should be scheduled by the GP.

Changes, including stopping, switching or amending the ONS prescription should be communicated by the clinician to the patient, and any member of the healthcare team involved in the patients' nutritional care e.g. care home team, GP, dietitian. A dietetic treatment summary should be completed following dietetic assessment and shared with appropriate members of the healthcare team as above.

If a patient fails to attend or engage with oral nutritional supplement reviews on two or more occasions, it would be advised that their prescription is stopped and the patient informed that they require reassessment before a further prescription can be issued. This is to ensure that the product remains clinically effective and meets ACBS criteria.

Recommendations:
• When treatment goals are met, discontinue prescriptions for ONS and continue with the food first approach if needed. • ONS should not routinely be prescribed long term. • (section 1.3) provides guidance on when and how to stop ONS prescription. • If the patient wishes to continue taking ONS, but they no longer meet the prescribing criteria (e.g. MUST ≤1 and/ or the patient does not meet ACBS criteria) and/ or the nutritional goal for use of ONS has been achieved, OTC supplements and food based strategies (including food fortification and nourishing drinks) should be recommended as opposed to a continuation of the ONS prescription Patient Resources • Patients who fail to engage or attend two consecutive reviews of ONS the current prescription should be stopped and the patient informed.

Section 5

5.1 ONS Product Guidance

GP QUICK REFERENCE GUIDE FOR PRESCRIBING ONS Product Guide
Considering the range of ONS products available to prescribe, the 'Quick Reference Guidance' groups ONS products within their respective product range, providing information on the cost-effective product to prescribe within each group. In addition, information on price, nutritional content, flavours and volume per serve is included.

'Extended Reference ONS Product Guidance' Extended Product Guide
A resource that contains information of ALL types of ONS products available for prescription. It includes detailed information for all products including price, energy, protein, volume, electrolytes, allergens, IDDSI level, osmolarity and flavours available. This guidance is likely to be beneficial for specialist or secondary care dietitians who may need to utilise unique ONS for particular clinical conditions but are still encouraged to make cost-effective choices.

5.2 Utilising the Product Guidance to Appropriately Prescribe

The ONS algorithm (Section 1.1) provides information on cost-effective ONS to prescribe within each product group and should be utilised when recommending or prescribing the prescription of ONS in primary or secondary.

In the ONS product guidance, products in the **AMBER** and **RED** sections should only be prescribed following dietitian assessment and clear clinical indication. Dietitians recommending the prescription of these products in primary care (including on discharge from hospital) should ensure a clear and justified reason is communicated to the GP with evidence an ONS in the **GREEN** section has been trialled and not tolerated or inappropriate.

Dietitians discharging the nutritional care of patients to GPs and requesting GPs to review ONS prescriptions should:

- provide a clear agreed treatment plan (as outlined in **Section 4**),
- recommend a clinically appropriate and cost-effective ONS within the respective ONS group
- recommend a product to prescribe or trial prior to prescribing

With view to support GPs and primary care clinicians in line with SEL CCG guidance.

Dietitians should avoid requesting GPs to prescribe and review ONS products in the **AMBER** and **RED** section. To ensure disease specific and specialist ONS are prescribed when clinically indicated (e.g. modified consistency ONS) clear justification should be included in written communication to the GP.

Recommendations:
• Modular ONS (high fat and/or protein supplements) are not nutritionally complete, dietetic assessment should aim to ensure these are recommended only when appropriate for the patient and when other ONS are not suitable. • Do not prescribe red ONS products listed on **Extended Product Guide** these should not routinely be initiated in primary care, unless a dietitian has requested and clinically justified the product.

Section 6

6.1 ONS Prescribing Across the Continuum of Care

Guidance provided within this section should be followed to ensure appropriate prescribing practices across the primary and secondary care interface.

Dietetic Communication
All dietitians, whether working in the acute or community setting should make use of a standard dietetic letter template when communicating with GPs.

Standard letters or hospital discharge summaries should include clear and relevant information regarding:

- Reasons for dietetic input
- Outcomes of ONS and dietetic intervention
- Dietetic treatment goals / outcomes
- Review and monitoring plan
- Actions required by the GP
- Assessment of ONS prescribing criteria including ACBS criteria
- End date for prescription

An example of a standardised dietetic discharge letter can be found: https://www.malnutritionpathway.co.uk/health-resources (discharge resources)

To ensure the patient receives the appropriate ONS prescription all information should be clearly communicated as demonstrated in the below table:

****** PRODUCT DETAILS*****								
Name & Manufacturer	Flavour	Volume (ml/g) per serve	Quantity /serves per day	Total volume for 28days	Duration (weeks)	Prescription Type	Review date / End Date	Information for Prescription
Powder Manufacturer	Chocolate Strawberry Neutral Banana Ginger	57	BD	3192g	12	ACUTE	Insert date	
Ready to drink bottle Manufacturer	Banana Chocolate Strawberry Vanilla Natural	200	BD	11200	12	ACUTE	Insert date	
Further ONS prescription is not required beyond review date above, unless requested by a dietitian								

Recommendations:
• Dietetic prescription request letters should include ACBS criteria, an indication if first line products are suitable and an end date for the prescription • If the above are not clearly documented on a nutrition prescription request sent by a dietitian, primary care clinicians are advised to switch to first line products see **Product Guide** • If further clarification is required it would be advised that the primary care clinician contacts the dietitian involved in the patients care.

6.2 Managing prescription requests following discharge from Secondary Care

ONS are often prescribed while in hospital and may be included in the transfer of care document (e.g. discharge drug summary or 'to take home' medications) without an accompanying dietitian letter. Not all patients commenced on ONS during their inpatient episode will have been referred for ongoing dietetic assessment nor automatically require ONS prescription once home. Patients may have required ONS whilst acutely unwell or recovering from surgery, but once discharged to the community setting and eating normally the need is often negated. Following discharge to primary care, the need for ONS prescription should be reviewed in line with local guidance and should consider changes in nutritional intake and clinical condition. The patient's nutritional status should also be reviewed to ensure an appropriate treatment and management plan is in place.

- **Supplements requested to continue in primary care on FP10 prescription should meet the SEL primary care ONS prescribing criteria**. If the patient does not meet defined criteria, OTC supplements, food first and homemade nourishing drinks should be recommended Patient Resources

- If the patient meets **ONS prescribing criteria**, the ONS product prescribed should be in line with the SEL ONS Product Guidance. ONS should be prescribed on **an acute 4 -12 week prescription and reviewed prior to continuing the prescription**. Avoid adding prescriptions for ONS to the repeat template. This ensures regular review against treatment goals and ensures product compliance and suitability.

- If correspondence from secondary care does not include a clinical reason or rationale why a first line produce cannot be used, primary care clinicians are encouraged to swap to first line products. If there has been no dietetic assessment during an acute admission and no highlighted nutritional concerns all ONS products should be stopped (e.g ONS on TTOs under 'new meds started this admission').

- ONS products in the **AMBER** and **RED** section prescribed during secondary care admission should **only continue post-discharge if the patient will remain under dietetic review** or if ONS in the **GREEN** section are contraindicated.

- Ideally, the patient will receive a trial of the ONS prior to changing the prescription. If unable to provide the trial in secondary care advising the GP on a clinically suitable and cost effective ONS to trial in primary care will support the GP prescribing in line with SEL Guidelines.

Recommendations:
• Following discharge from secondary care, it is suggested that any new ONS started that admission are not continued unless there is evidence that the patient has been assessed by a dietitian. • If there are nutritional concerns, follow (section1.2) pathway for managing malnutrition risk or refer to dietetic services. If ONS required suggest 1st line community product for acute 4-12weeks prescription with a clear end date.

Section 7

7.1 Inappropriate Prescribing

- 1kcal/ml sip feeds which are clinically and less cost effective than 1.5kcal/ml products
- Patients relying on ONS as a sole source of nutrition should be under the care of a dietitian to ensure ONS are prescribed appropriately and the patient's dietary intake is nutritionally complete
- Powder ONS are not nutritionally complete and should not be recommended as a sole source of nutrition.
- Milkshake style ONS that are not first or second line products in primary care
- Care homes should provide adequate quantities of good quality food and hydration as per Regulation 14, CQC guidance. Having appropriate provision of food and hydration will mean that the use of unnecessary nutrition support is minimised. ONS should not be used as a substitute for the provision of food. Suitable snacks, food fortification as well as homemade milkshakes and smoothies and over the counter products can be used to improve the nutritional intake Patient Resources of those at risk of malnutrition. Care home residents should be prescribed cost effective powdered ONS as a first line option as long as this is not clinically contraindicated.

Recommendations:
• Specialist products e.g. which may be required for particular patient groups, e.g. renal patients, or those with bowel disorders, those with pressure ulcers, or those with dysphagia or red products as listed on **Extended Product Guide** should not be prescribed in primary care unless requested and clinically justified by a dietitian

7.2 Avoiding Pitfalls in Prescribing

Errors in ONS prescribing frequently occur and can result as a consequence of insufficient information provided in the ONS prescription request, common errors include;

	Key Issue	Consequence	Solution
Total Volume Prescribed	Over or under prescribing e.g. prescribing two packets of supplements instead of two bottles/sachets per day	Increased costs associated with large volume of ONS prescribed inappropriately. Patient receiving/taking the incorrect volume	• Refer to ONS Product Guidance for advice on total volume of ONS to prescribe • If under a dietitian, check dietitian letter
	***Example**: Prescription for two packets of a supplement per day (Foodlink Complete Powder, 399g twice daily) instead of two serves per day (Foodlink Complete Powder 57g twice daily)*		
Incorrect Product Prescribed	Full product name is not provided in the prescription request letter	Incorrect product prescribed to the patient. Often products with similar names are more expensive and of less clinical benefit to the patient	• Refer to ONS Product Guidance to ensure the product requested is in line with guidelines • If under a dietitian, check dietitian letter
	***Example:** Ensure Liquid (a 1kcal/ml low calorie high cost item) prescribed instead of Ensure Plus Milkshake Style (1.5kcal/ml, lower cost item).*		
Duration	ONS prescribed on repeat instead of acute	ONS prescriptions continue on repeat without review; patients receive no follow up	• ONS prescribed on acute only; do not prescribe on repeat • If under a dietitian, refer to dietitian communication and follow advice on specified time frame for ONS prescription
	***Example:** repeat (reissued monthly without GP review); or acute (reissued for a specified timeframe e.g. acute for 2 months = monthly prescription issued twice and stopped)*		

For GPs to electronically prescribe an ONS on their electronic system and avoid errors in prescribing, they require the below information clearly presented. The preferred method for providing this information to general practices across SEL is outlined in the ABOVE table (Section 6.1)

Section 8

8.1 Specialist Nutrition Intervention

Patients identified at risk of malnutrition, with continued concerns following advice on food first and homemade nourishing drinks should be assessed against local dietetic team referral criteria and referred as appropriate.

Patients presenting with acute/chronic illnesses which may require specialist dietetic and nutritional intervention should be referred to the appropriate dietitian. This may include patients' presenting with disease related malnutrition/nutritional concerns relating to their physical and mental health and wellbeing, for example; malabsorption, chronic/acute organ failure or illness i.e. renal impairment, mental health, vascular disease, eating disorders, cancer, dementia, diabetes, dysphagia, HIV, and autoimmune related illnesses.

8.2 Dysphagia

Patients presenting with dysphagia should be referred to a Speech and Language Therapist (SLT) for specialist assessment, monitoring, intervention and advice. ONS recommended and prescribed should follow recommendations as per the SLT assessment.

Guidance regarding appropriate International Dysphagia Diet Standardisation Initiative (IDDSI) level supplements is found on the Extended Reference ONS Product Guidance for Dietitians'. Please be aware some products cannot be thickened with standard thickener and others require specific storage to meet specified IDDSI levels. This could result in an unsafe prescription, therefore please refer to manufacturers guidelines prior to prescribing to ensure these requirements are met and SLT recommendations adhered too.

8.3 Palliative Care

Prior to prescribing ONS in palliative care, the individual patient's prognosis, treatment plan, and quality of life should be carefully considered. It would be encouraged that clinicians refer to the GSF Proactive Identification Guidance, this tool can help to support earlier identification of patients nearing the end of their life. The rationale for supplement use should be considered with an emphasis on support and information provided to patient, their family and carers surrounding the benefits of encouraging small meals, snacks and drinks to include the patient's preferable foods. An emphasis should be placed on minimising barriers and alleviating symptoms including pain, nausea, and constipation.

Management of palliative patients can be divided into three stages: early palliative care, late palliative care and end of life care. Care aims will change through these stages.

- **Early palliative care treatment,** patients with months or years to live may be receiving palliative care to help improve their quality of life. Nutritional screening and assessment should be a priority, and appropriate early intervention could improve the patient's response to treatment and potentially reduce complications. For patients whom nutritional status is compromised, the use of ONS may be beneficial and may improve treatment outcomes.

- **Late palliative care,** at this stage the patient's condition is deteriorating and they may experience increased symptoms. The nutritional content of meals is not of primary importance and main aim is to maximise quality of life, including comfort, symptom relief and enjoyment of food. Nutritional support should focus on the provision of favourite foods and drinks, palatable and preferred by the patient to help maximise quality of life. The goal of nutritional management is not for weight gain or reversal of malnutrition. **Nutrition screening, weighing and initiating ONS prescriptions is not recommended. End of Life Palliative Care** The use of ONS is unlikely to improve nutritional status or prolong life when an individual is nearing last days of life. The aim of any intervention should be to provide comfort for the patient and offer mouth care, sips of fluid and mouthfuls of food as desired. Therefore, referral to community dietetics for nutritional intervention including the need for oral nutritional supplements in unlikely to be appropriate in end of life and late palliative care.

Considering the aim of any intervention for patients in **end of life palliative care** is to improve quality of life; if a patient is already established on an oral nutritional supplement and enjoys/tolerates the product then it is not recommended to discontinue the product. On reviewing the ONS prescription, products should only be discontinued/reduced if a patient is not tolerating/dislikes the product or would prefer to focus on favourable foods and fluids. If the patient is not completing or tolerating the full volume of ONS prescribed, the prescription volume should be reduced. The volume of ONS tolerated should be reviewed frequently to avoid waste.

8.4 Diabetes

The dietary treatment of malnutrition often requires patients to have foods higher in fat and sugar than is usually recommended. Treating malnutrition should be a priority and for this reason, tighter monitoring of blood glucose levels is recommended. It is desirable to keep the blood glucose levels in a reasonable range as per local guidance to prevent undesirable side effects and diabetes medications may need to be reviewed with dietary intervention. Malnutrition risk should be reviewed with dietary advice to optimise both nutritional status and diabetic control reflecting the diagnosis, prognosis and degree of malnutrition.

ONS (milk and savoury based) are appropriate for patients with diabetes however their blood glucose levels may require careful monitoring with medication reviews provided as appropriate. If concerns are present regarding high and unstable blood glucose levels consider recommending a neutral flavour ONS due to the lower glycaemic index; contact your local dietitian for additional information and advice.

If ONS is indicated, choose milky based products rather than juice based (due to lower glycaemic index (GI) value). If milk and savoury ONS are not well tolerated, and concerns continue regarding increasing risk of malnutrition; fruit juice based supplements may be provided. Juice based and powdered ONS supplements have a higher sugar content and therefore blood sugar levels should be monitored closely.

8.5 Substance Misuse

Substance misuse is NOT a specified ACBS indication for ONS prescription. ONS prescribing in substance misusers (alcohol and drug misuse) is an area of increasing concern, due to both the cost and question of appropriateness.

Substance misusers may have a range of nutrition related problems such as:

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

Reasons for nutrition related problems include:

- Drugs themselves – can often cause poor appetite, reduce pH of saliva leading to dental problems, constipation, craving sweet foods (drug misusers in particular)
- Chaotic lifestyles
- Lack of interest in food and eating
- Poor dental hygiene (drug misusers in particular)
- Irregular eating habits
- Poor memory
- Poor nutrition knowledge and skills
- Low income, intensified by increased spending on drugs or alcohol
- Homelessness / poor living accommodation
- Poor access to food
- Infection with HIV or hepatitis B and C
- Eating disorders with co-existent substance misuse

Problems often created by prescribing ONS in substance misusers:

- Once started on ONS it is difficult to stop the individual taking them
- ONS taken instead of meals and therefore no benefit
- They may be given to other members of the family/friends
- Often sold and used as a source of income
- Can have poor compliance for review therefore making it difficult to weigh them and re-assess need for ONS
- ONS may be taken sporadically depending on other factors therefore unlikely to provide benefit

ONS should NOT be prescribed in substance misusers unless ALL the following criteria are met:

- BMI<18kg/m^2
- AND there is evidence of significant weight loss (>10%)
- AND there is a co-existing medical condition which 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

If the individual does not meet the criteria, recommend OTC supplements, food first and home-made nourishing drinks Patient Resources

If ONS is initiated:

- The patient should be assessed by a dietitian. If they fail to attend on two consecutive occasions, ONS should be discontinued

- Maximum prescription should be for 600 kcal/day (twice daily) unless advised otherwise by dietitian.
- NO repeat prescriptions
- Prescribed on a short term basis only (i.e. 1-3 months)
- If there is no change in weight after three months, the need for ONS should be reviewed with the view to reduce and discontinue.
- If weight gain occurs, continue until usual weight or healthy weight is reached, and reduction of ONS will be negotiated

Recommendations:
• The above patient groups can be particularly challenging for primary care clinicians; GPs and primary care clinicians are frequently requested to prescribe ONS which may not be appropriate to prescribe. • To support implementation of these guidelines local CCG Prescribing Support Dietitians and Medicines Optimisation Teams may be contacted.

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