Malnutrition remains an under-recognised problem in the community. This was highlighted by a recent campaign by the British Dietetic Association, ‘Mind the hunger gap’ (www.mindthehungergap.com), which illustrated that over one million older people living at home in the UK are suffering from malnutrition. However, malnutrition is not restricted to the elderly — every age group in the community is at risk of malnutrition, including those with multiple comorbidities such as diabetes or heart disease; those undergoing complex surgery; those from lower socioeconomic groups, and those with substance misuse problems.

A great deal of effort has already been put into encouraging screening of all patients for their risk of malnutrition on admission to hospital so that resources can be targeted to those most at need. However, screening also needs to be encouraged in the community (Elia, 2003). The Malnutrition Universal Screening Tool (MUST) is the tool recommended by the British Dietetic Association and this is now widely used (Elia, 2003). Details on how to complete this can be found on the British Association of Parental and Enteral Nutrition (BAPEN) website (http://www.bapen.org.uk/pdfs/must/must_full.pdf), and it was summarised in the author’s earlier article on malnutrition in this journal (Taylor, 2014).

If malnutrition is not tackled, an individual’s quality of life can be severely affected (Stratton et al, 2003), resulting in:

- Reduced skin integrity: this can cause skin breakdown and pressure ulcers but also reduces wound healing
- Depression and anxiety: this can result in an ever-decreasing cycle where patients become less motivated to look after themselves or cook meals, resulting in a further deterioration in their nutritional state. This increase in illness results in increased admissions to hospital
- In younger adults, malnutrition can reduce the ability to conceive
- Thinner, malnourished individuals will also find it difficult to keep warm, which can add to the financial burden of heating and reduce money available for food.

Preventing malnutrition is essential, however, it is also important that people who are malnourished receive help to meet their nutritional needs when illness, or isolation, for example, has made them increasingly vulnerable. This article aims to provide some practical steps on how malnutrition can be managed in the community setting.

IDENTIFYING THOSE AT RISK OF MALNUTRITION

Screening using the MUST tool is an ideal way to identify those at risk (Taylor, 2014), however, in the author’s clinical experience, other factors that point to a potential for malnutrition include:

- Patients struggling with general levels of activity and/or increasingly staying at home
- Depression and a lack of motivation
- Skin changes, in particular increased marking or breakdown of skin on the bony prominences

* Ensure Compact vs Fortisip Compact vanilla flavour (p<0.001; n=111)
** Older adults asked to drink 2 bottles per day for 7 days (n=25)

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TASTE.
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Clothes that look too large, or where people wear lots of layers to help keep themselves warm.

By regularly monitoring patients and asking polite questions about the kind of topics mentioned above, community nurses can begin to better understand their nutritional status. It is also important to remember that a person’s nutritional state can deteriorate very slowly or quite quickly (depending on the severity of any illness and the reduction in their nutritional intake), ranging from a rapid reduction within a week to a gradual change over months. A more severe illness will have also put greater metabolic stress on an individual, and, while critically unwell, he or she will be less likely to eat (Scott et al, 1999).

Regular reviews and accurate documentation should help the community nurse to identify a problem before it starts to severely affects a person’s health.

**IDENTIFYING THE CAUSE OF MALNUTRITION**

Once a patient has been identified as being at risk or malnourished, further investigations can help to identify possible solutions. However, malnutrition is often multifactorial and can result from a combination of problems. Common causes include (Thomas and Bishop, 2007):

- Reduced dietary intake when there is adequate food available, particularly in the following circumstances:
  - Anorexia due to illness, anxiety or depression
  - Nausea due to illness or treatment
  - Poor mobility or limited hand function affecting the ability to eat or cook
  - Swallowing problems that reduce the variety of foods that can be eaten
  - Breathing problems such as chronic obstructive pulmonary disease (COPD)
  - Poverty and deprivation
  - Self-neglect
  - Lack of knowledge about nutritional foods
  - Where the patient’s medical condition requires increased nutrition, including:
    - Following surgery, trauma, burns or infection
    - Where patients experience repeated spasms such as with some neurological conditions
    - Some medical treatments such as chemotherapy
  - An inability to utilise or absorb nutrients occurs in some conditions, including:
    - Pancreatic insufficiency
    - Some drug therapies
    - Inflammatory bowel disease.

It is important to remember that patients may have been struggling with their appetite or poor dietary intake for such a long time that it has become almost normal for them. A recent qualitative study (undertaken by the author as part of a master’s in clinical research) investigated patients’ perceptions of factors that had contributed to their high risk of malnutrition. This involved interviewing elderly patients admitted to hospital who had been identified according to their MUST score as being at risk of malnutrition. Some of the patients did not realise they were even at risk of malnutrition, or did not feel it was relevant to discuss with their GP.

Getting to know the patient and assessing their dietary intake and reasons for poor intake is vital when seeking to fully understand any risk of malnutrition.

**MANAGEMENT**

As outlined above, there are many reasons for malnutrition, however, some of the solutions may be simple and include (Thomas and Bishop, 2007):

- A change in medication to relieve side-effects such as loss of appetite, changes in the ability to taste
- Laxatives to resolve constipation
- Antiemetics to control nausea.

However, non-medical solutions are often needed and may require a more detailed assessment, such as investigations into patients’ energy levels, skin condition, levels of motivation, general health and coping strategies, as well as any assistance they are receiving. Alongside this, nurses should ensure that there is adequate support for meal provision, which could involve patients receiving help with shopping or cooking meals.

However, although this kind of help is often provided, patients may still not eat meals that have been prepared for them. In the author’s research mentioned above, some patients admitted that they did not always eat meals that had been prepared for them, but did not tell anyone for fear of causing offense.

Enquiring in more detail about what types of foods are being eaten by patients is also important, particularly as meals can become repetitive when others are helping with the shopping, as they often buy the same foods. In turn, this reduces the variety of nutrients available and education on a balanced, nourishing diet may be required for both the patient and any carers/family.

**Consistency**

Due to ageing or illness, patients may begin to change the consistency of the food they eat, choosing softer options because of tiredness, lethargy, ill-fitting dentures or swallowing problems (Thomas and Bishop, 2007).

Investigating and discussing patients’ dietary intake with them can help to identify this. Similarly, in order to soften food it needs to be cooked for longer, resulting in some of the vitamins being destroyed. Patients may also choose naturally soft foods while avoiding the options that are more difficult to chew such as meat, thereby reducing their protein intake. Blending food can also dilute nutrients.

In the author’s experience, while such changes in intake can be due to a swallowing problem, they may also be due to ill-fitting...
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dentsures. A referral to a speech and language therapist or dentist may be appropriate in these cases. Similarly, if a person has genuine swallowing problems, nurses can seek advice from hospital and community dietetic departments on how to ensure that different food consistencies still provide nourishment.

Patients are often very capable at adjusting their lives to cope with challenging situations. However, in the author’s study mentioned above, instead of asking for help in identifying what caused them to eat differently, patients often simply adapted their diet. This can mean that the causes of any dietary changes may only be identified through detailed questioning.

PRACTICAL SOLUTIONS

While nutritional supplements are often considered the answer, these can be costly and a ‘food first’ approach is recommended as the first line of treatment (Krassie et al, 2000). The support required will depend on the individual’s situation, however, the following points may be helpful.

Are patients eating regularly enough?
By eating little and often it is possible for individuals to meet all their nutritional requirements (Gall et al, 1998). However, some people may not want to eat between meals if they are not used to it, or fear that it will put them off eating their main meal.

Community nurses can help to make people aware that small portions eaten more regularly might provide them with a higher nutritional intake than eating a slightly larger portion once or twice a day (Thomas and Bishop, 2007). It may simply be a case of changing what would previously have been a dessert to a between-meal snack.

Are patients missing meals?
Patients may be eating a few biscuits as a snack and missing meals. However, there are more nourishing snacks that could be suggested, such as:
- Cheese and biscuits
- Full-fat yoghurts
- Fruit cake
- Teacakes/scones/crumpets
- Handfuls of nuts
- Cereal bars.

See Table 1 for an illustration of the nutritional content of different foods.

Are meals nourishing enough?
There are some simple techniques for making meals more nourishing. In the author’s experience, dairy foods are particularly useful in that they contain a concentrated source of protein and calcium without adding significant volumes (Table 1). These include:
- Cheese — can be melted onto mashed potatoes and vegetables, added to soups or sauces, and sprinkled over pasta dishes
- Cream or evaporated milk — can be added to soups, potatoes, sauces, and breakfast cereals
- Yoghurts — can be added to puddings or potatoes.

Nourishing drinks
In the author’s experience, if patients find it easier to drink than to eat solid food, there are many nourishing drinks that can be easily prepared:
- Milkshakes can be made with whole milk, thereby increasing the fat content while all other nutrients remain intact. Similarly, adding ice cream to a milkshake will further increase its nutritional content
- Soups can be thickened with added cream or cheese.

Lunch clubs
Social lunch clubs can have a positive effect on those struggling with isolation, as they supply regular hot meals as well as providing company and social interaction.

Many community groups such as churches organise lunch clubs. Understanding what is available locally will help community nurses provide patients with useful information.

Ready meals
So-called ready meals can be a useful alternative. The quality and variety of these pre-prepared meals is increasing and if a patient or carer finds preparing food too tiring, they can be used as a substitute. Nurses should encourage variety to prevent boredom and ensure a wide range of nutrients is consumed.

Local services
Local community and hospital dietetic departments may have literature available for patients, which covers the strategies mentioned above. Community nurses should always check to see what resources are available locally to provide patients with different options so that they can choose the most acceptable one, for example, would they like to have ready meals delivered or visit a lunch club.

However, even when dietary suggestions have been made, it is vital for nurses to follow up with patients regularly. Any nutrition plans may need to be changed to ensure that they are still practical if the patients’ circumstances change, for example, if they become healthier and more mobile and

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However, even when dietary suggestions have been made, it is vital for nurses to follow up with patients regularly. Any nutrition plans may need to be changed to ensure that they are still practical if the patients’ circumstances change, for example, if they become healthier and more mobile and
require higher energy levels; similarly, if they develop additional health problems and require more input.

Regular reviews will initially be required more frequently until a plan has been shown to be sustainable. Once established, follow up can become less frequent, although nurses should still monitor patients regularly.

If patients are not coping with the recommended plan, for example, if there is a deterioration in their medical condition, a loss of a family member, or reduction in swallowing capability, they may require more specialist help, such as referral to a dietitian.

NUTRITIONAL SUPPLEMENTS

There are numerous nutritional supplements/oral sip feeds available on prescription (e.g. Ensure®, Abbott Nutrition; Fresubin®, Farmaline). Some of these supplements are nutritionally complete, while others are low in fat or higher in protein and come in a thicker consistency with more fibre. They are also available in different volumes and include a vast range of sweet and savoury flavours.

Supplements are useful for patients who require additional nutrients and can be prescribed for specific conditions, such as inflammatory bowel disease, dysphagia and disease-related malnutrition linked to conditions such as chronic obstructive pulmonary disease (COPD), cancer, cystic fibrosis and neurological impairment (British Medical Association/Royal Pharmaceutical Society [BMA/RSP], 2014).

However, the choice of products is often bewildering and each company will produce their own ranges — also, some supplements may not be interchangeable as they are designed for specific conditions, such as those with swallowing difficulties or renal disease. Similarly, some services will have contracts with specific companies and, therefore, making links with a local dietetic department will help nurses understand which supplements to suggest for specific conditions.

It may be appropriate for nurses to discuss alternatives with the local dietetic department to ensure that patients are being prescribed the most suitable supplement for their condition. However, care must be taken with patients who have renal disease or diabetes, as supplements can alter their biochemistry and blood glucose levels.

Other dietary restrictions also need to be considered, for example lactose intolerance and vegetarianism, while fat malabsorption can occur in diseases of the pancreas, such as cystic fibrosis and pancreatitis, or following pancreatic surgery (Thomas and Bishop, 2007).

It is always useful for nurses to find out which dietary supplement company their organisation uses and investigate the product range, as well as checking the indications for supplements being taken by their patients.

Some supplements are available to purchase in pharmacies, including build-up drinks and soups. Patients can find these very useful as an additional source of nutrients, adding them to their diet as nourishing snacks.

This will enhance patients' nutritional intake with minimal extra effort when the food first approach is considered too onerous.

CONCLUSION

In the community, malnutrition remains a multifactorial problem that is complex to resolve. It may have been caused by a sudden change in the patient's medical or social situation, or both.

The nutritional support of patients continues to be a challenge for nurses. In the community, when there is less ‘control’ of what is eaten it is even more of a problem.

This article gives practical, advice and evidence to inform the reader of the importance of nutrition, assessment and what can and should be done to improve nutritional intake.
Prompt action can prevent the problem escalating and dramatically affecting the patient’s health.

Malnutrition may also result from a chronic problem that has resulted in years of gradual deterioration. In this case, more detailed and supportive treatment from family, friends and healthcare services may be required to help implement dietary changes.

As habits become established they become more difficult to change, and this is true of eating and drinking. By using some of the ideas highlighted above, and with regular monitoring and support, patients in the community are more likely to recover quickly from malnutrition, or ideally not develop it in the first place.

REFERENCES


KEY POINTS

- Malnutrition is defined as ‘a state in which a deficiency of energy, protein and/or other nutrients causes measurable adverse effects on tissue/body form, composition, function or clinical outcome’.
- Community nurses have an important role to play in identifying patients at risk of malnutrition and ensuring that they receive appropriate nutritional support.
- Evidence suggests that malnourished people are also repeat attenders at GP surgeries, have higher prescription costs and have twice as many hospital admissions than the well-nourished population.
- As health care moves to more community-based care, there needs to be a shift in efforts from hospitals to community to ensure that malnutrition is tackled.

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