

Generic Nutritional Care Pathways for the Management of Malnutrition in Older People in the Community

Introduction

‘Older People’s Essential Nutrition’ (OPEN) is an initiative that has been piloted in Eastleigh to develop and evaluate an integrated approach for the provision of good nutritional care for older people. Part of the initiative has been to develop nutritional care pathways, based on national guidelines, which provide guidance on malnutrition screening, individualised care plans, co-ordination between relevant workforces and timely care and review. Care pathways developed for use with the OPEN initiative were adapted from the pathways developed by the “Dorset Nutritional Care Partnership For Adults”. For more information on the Dorset care pathways, please visit the Dorset For You strategy page at www.dorsetforyou.com/nutritional-care-strategy. Whilst this information and the attached care pathways refer to ‘older people’, they can be used for all adults in all community settings.

These care pathways are for use with older people who have been screened for malnutrition using BAPEN’s ‘MUST’ screening tool. Once an older person is screened using ‘MUST’, it’s essential to initiate an appropriate nutritional care pathway to ensure they receive the appropriate advice, information and treatment to improve their overall nutrition and malnutrition risk.

The OPEN initiative has now adapted the nutritional care pathways used in the Dorset and Eastleigh pilots, to make three generic pathways. This means that you can use and adopt these pathways in your own localities, simply by making a few additions to make them local to you (e.g. the specific names of your local teams or healthcare professionals who will be involved in care). The required additions are highlighted by the blue text in square brackets. Please note that these care pathways are not suitable for people receiving End of Life care.

The OPEN Nutritional Care Pathways

Three generic care pathways have been put together, as follows:

OPEN Nutritional Care Pathway 1

- For use with older people visited once or annually, or by teams who have agreed to carry out initial screening, but will refer any ongoing care to another team
- May include a range of different staff such including GPs, pharmacists, social care teams, Allied Health Professionals and voluntary sector staff

OPEN Nutritional Care Pathway 2

- For use with older people seen more than once, e.g. those on a caseload
- Used for staff who will refer on to another team or service if MUST score has not improved after one month
- May include staff such as social work teams, rehabilitation teams, Occupational Therapists

OPEN Nutritional Care Pathway 3

- For healthcare teams to use with older people seen more than once, and those, who would follow the older person’s care through, rather than referring on to another team if MUST score was not improving
- For use by those who receive referrals from others for those who have been found to be at risk
- May include groups such as GPs, Dietitians, Practice Nursing, District Nursing, Community Matrons and Integrated Care Teams

How to use the OPEN Nutritional Care Pathways

For all three pathways:

- From the generic pathways in this document, localised pathways will need to be developed in conjunction with your local teams
- Add the names of agreed local organisations who can support older people. Supporting the social reasons for malnutrition is very important – there may be local luncheon groups, befriending services and transport support available from charities (e.g. Age Concern) and churches
- Older people with a ‘MUST’ score of 0 may benefit from leaflets / information on healthy eating and local support or activity groups. You can insert the name(s) of your preferred leaflet(s), or ones you’ve developed locally. Examples of nationally available leaflets include Change 4 Life leaflets and those by national charities, such as the British Heart Foundation
- For older people with a ‘MUST’ score of ≥ 1 , insert the name(s) of your preferred leaflet(s). This could include the OPEN leaflet ‘Eating well, feeling good: Recognising and treating malnutrition’, which can be downloaded using the following link:
<http://wessexahsn.org.uk/img/projects/OPEN%20awareness%20leaflet%20A4L%20locked.pdf>
- Liaise with your local dietetic team, who can provide support with using these care pathways. Insert their contact details into the relevant spaces

For the OPEN Nutritional Care Pathway 1:

- It’s important that if an older person who has been identified as having a ‘MUST’ score of 1, 2 or 3 is not going to be seen again by your service, you refer them on to an appropriate team or healthcare professional for ongoing monitoring. You will need to insert the name of this agreed local team or healthcare professional
- Decide on the professional or team to alert and pass on referrals for older people with a ‘MUST’ score of 4 or more. For example this could be the Intermediate Care Team, senior Community Nurses and the GP

For the OPEN Nutritional Care Pathway 2:

- If after one month an older person has a ‘MUST’ score of ≥ 2 with no improvement, insert the name of the agreed healthcare team to contact, for example the Community Matron
- If you are not revisiting and the older person has a ‘MUST’ score of 1, 2 or 3, you need to refer them on to an appropriate team or healthcare professional for ongoing monitoring. You will need to insert the name of this agreed local team or healthcare professional
- Decide on the professional or team to alert and pass on referrals for older people with a ‘MUST’ score of 4 or more. For example this could be the Intermediate Care Team, senior Community Nurses and the GP

For the OPEN Nutritional Care Pathway 3:

- If you are not revisiting and the older person has a ‘MUST’ score of 1, 2 or 3, you need to refer them on to an appropriate team or healthcare professional for ongoing monitoring. You will need to insert the name of this agreed local team or healthcare professional
- Decide on the professional or team to alert and pass on referrals for older people with a ‘MUST’ score of 4 or more. For example this could be the Intermediate Care Team, senior Community Nurses and the GP

Additional information

Please note that in the community, the ‘Acute Disease Score’ (Step 3) is rarely used. The Acute Disease Score, which adds a further ‘2’ to the overall ‘MUST’ score, is only allocated if an older person is acutely ill and there has had (or is likely to be) no nutritional intake for more than five days. The majority of people fitting these criteria will be hospital inpatients or on the end of life pathway.

Information on how to carry out screening using the ‘MUST’ screening tool can be found on the BAPEN website – www.bapen.org.uk. The BAPEN website includes the MUST tool itself, along with the charts to calculate BMI, weight loss, height from ulna length, and mid upper-arm circumference. To download the PDF with instructions on completing ‘MUST’ screening and view the associated charts, visit: www.bapen.org.uk/pdfs/must/must_full.pdf

BAPEN have recently updated their website to be accessible on all mobile devices. They have replaced the MUST app with their MUST Calculator, which can be used to easily calculate someone’s risk of malnutrition. The MUST Calculator can be found on www.bapen.org.uk/screening-and-must/must-calculator.

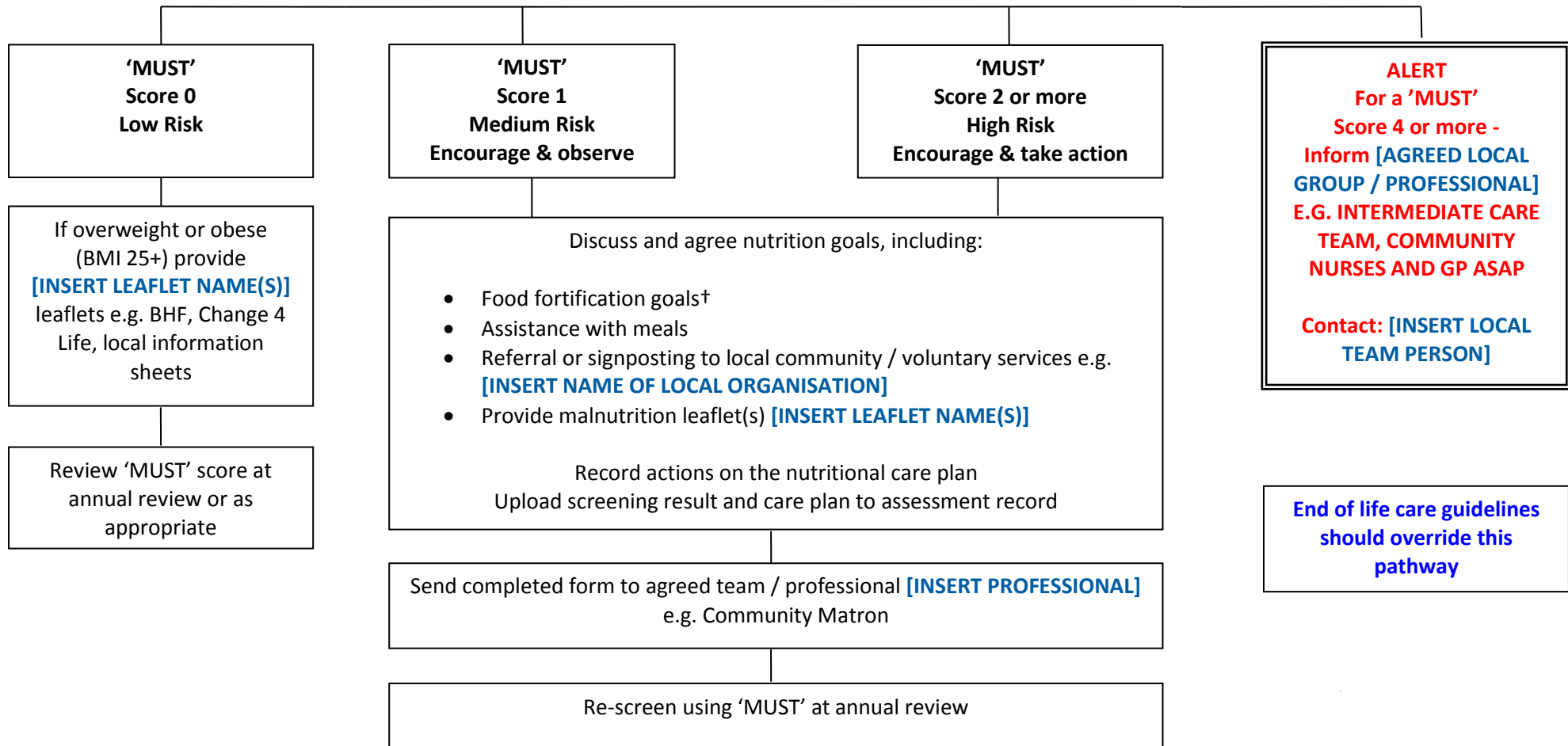
Version 1 / June 2016

These nutrition Care Pathways have been adapted from pathways developed by the Dorset Nutritional Care Partnership For Adults

OPEN Nutritional Care Pathway 1: For use with older people visited once OR annually

†Please check local guidance on food fortification, input required from local dietetic services prior to finalising your pathway.

If an older person is on a special diet that may be affected by the fortification of food e.g. diabetes/low fat diet then GP or dietetic advice must be sought prior to introducing fortification.



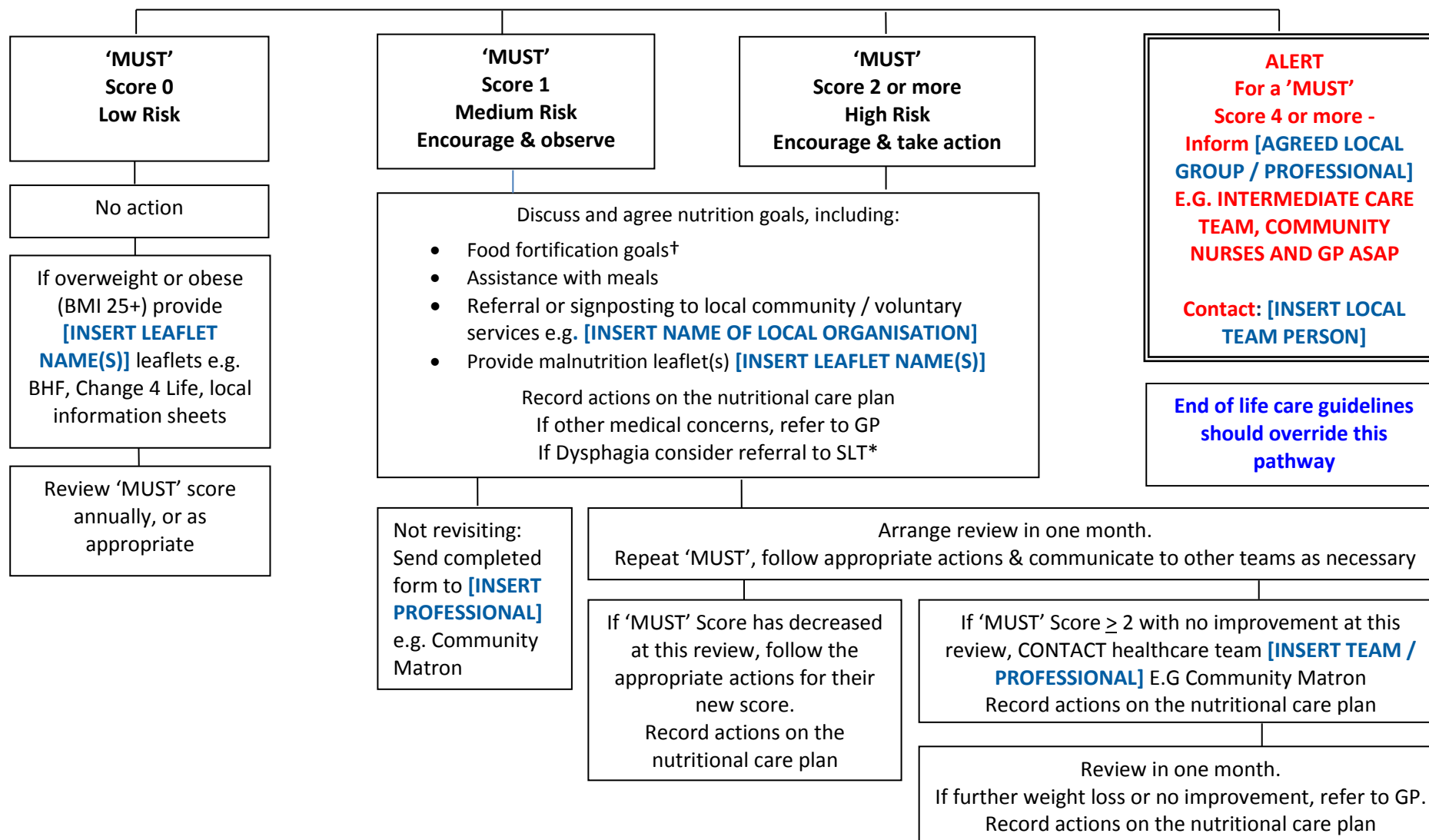
Please contact **[INSERT NAME OF NUTRITION TEAM/DIETETIC DEPARTMENT]** for assistance with completing the care pathway
 Email **[INSERT EMAIL ADDRESS]** Tel: **[INSERT PHONE NUMBER]**

OPEN Nutritional Care Pathway 2: For use with older people seen more than once

*SLT – Speech and Language Therapist **ONS – Oral nutritional supplements – refer to ONS formulary

†Please check local guidance on food fortification, input required from local dietetic services prior to finalising your pathway.

If an older person is on a special diet that may be affected by the fortification of food e.g. diabetes/low fat diet then GP or dietetic advice must be sought prior to introducing fortification.



Please contact [INSERT NAME OF NUTRITION TEAM/DIETETIC DEPARTMENT] for assistance with completing the care pathway

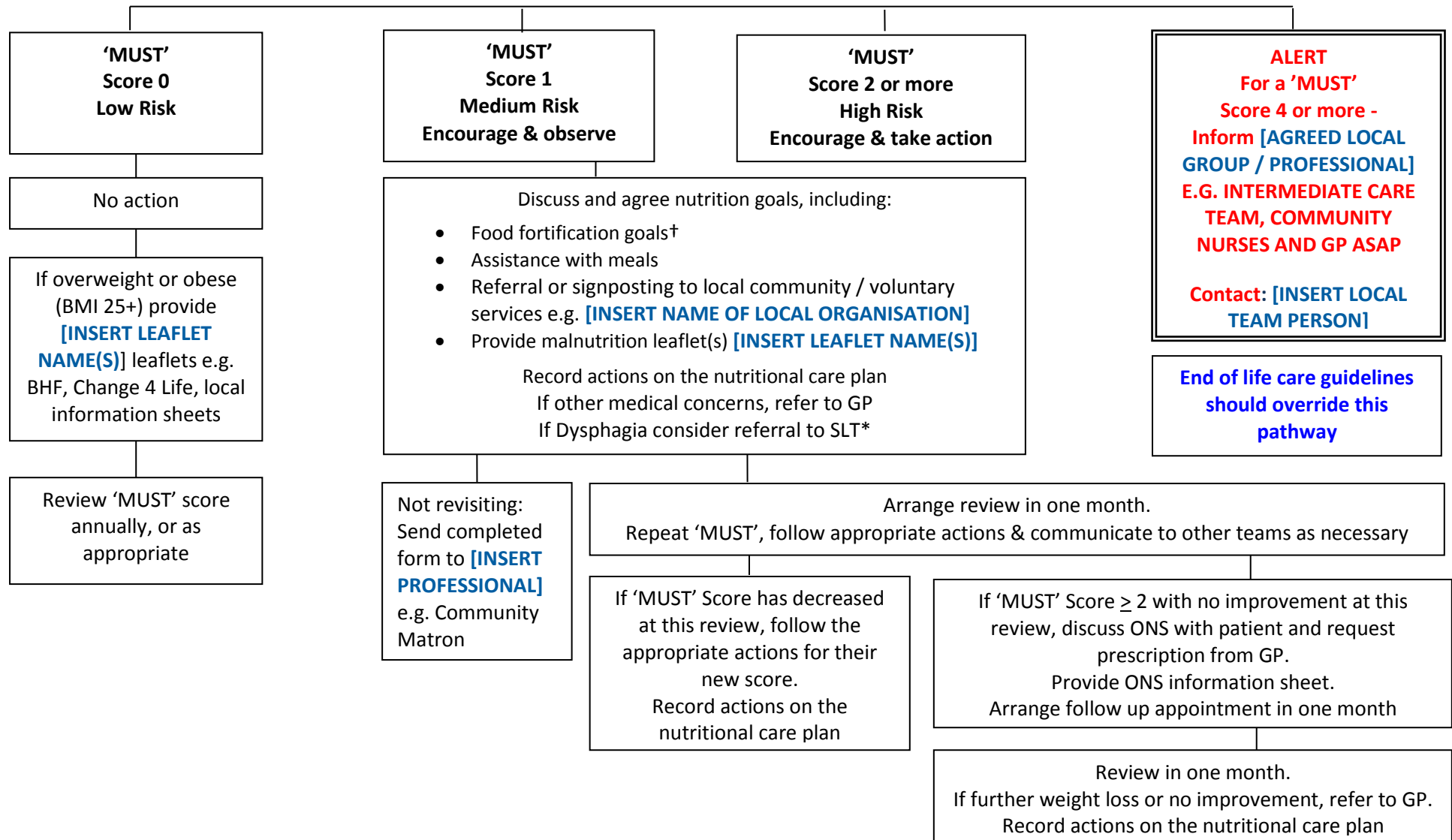
Email [INSERT EMAIL ADDRESS] Tel: [INSERT PHONE NUMBER]

OPEN Nutritional Care Pathway 3: For use with older people seen more than once & with those referred from other community teams

*SLT – Speech and Language Therapist **ONS – Oral nutritional supplements – refer to ONS formulary

†Please check local guidance on food fortification, input required from local dietetic services prior to finalising your pathway.

If an older person is on a special diet that may be affected by the fortification of food e.g. diabetes/low fat diet then GP or dietetic advice must be sought prior to introducing fortification.



Please contact [INSERT NAME OF NUTRITION TEAM/DIETETIC DEPARTMENT] for assistance with completing the care pathway

Email [INSERT EMAIL ADDRESS] Tel: [INSERT PHONE NUMBER]

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