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Introduction
Foreword
From the Task Force chairs

Malnutrition is a major cause and consequence of poor health and older people are particularly vulnerable. It is estimated that in the UK around one million people over 65 years old are malnourished or at risk of malnutrition.¹

The human cost of malnutrition and dehydration are harrowing to both the individual and those that care for them. Food and water left out of reach, lack of support to eat and drink and supplements not given are frequent occurrences. One family’s experience of their mother’s care was just that. Despite desperate pleas with staff, she died.² In another case, an 81 year old widow was left at home without food and water, no contact and no support. She died a tragic death that could have been avoided.³

This guide is ambitious; malnutrition and dehydration are not recognised as problems in our society. Most people (older people, carers, professionals, commissioners and senior managers in health and social care) do not realise how common malnutrition is or how serious the consequences can be and so malnutrition and dehydration continue to go unrecognised and untreated.

There has never been a more urgent need to act. The final recommendations in the Francis Report² on the Mid Staffordshire NHS Foundation Trust Public Inquiry, the Care Quality Commission Dignity and Nutrition inspections⁴ and Adult Social Care Survey⁵ demonstrate that organisations are still repeatedly failing to provide older people with the basic right to food, drink and support when they need it.

The costs of malnutrition run into billions of pounds¹ in spite of proven interventions that can help prevent, identify and manage the problem and risks promptly and thereby reduce the human suffering and the astronomical associated costs.

The Malnutrition Task Force is an independent group of experts from health, social care and local government united to address preventable malnutrition and dehydration in hospitals, care homes and in the community. We believe that prevention and treatment of malnutrition should be at the heart of everything we do to ensure older people can live more independent, fulfilling lives.

Together, with a wide range of stakeholders, we have identified many excellent examples of practice and existing guides, tools and resources that are readily available. We have drawn from these the principles of best practice and developed a framework to support local health and wellbeing boards, commissioners, provider organisations and people at the front line of care to take action and make the changes needed.

We urge you to act now and put an end to this needless suffering and neglect of basic human rights so that older people receive the dignified and personalised care, support and treatment required to combat malnutrition.

We hope this guide will help you.

Dianne Jeffrey CBE DL Chairman

Dr Mike Stroud OBE Co-Chair
About malnutrition

What is malnutrition?

According to NICE (National Institute for Health and Care Excellence) guidance in Nutrition support in adults (CG32), malnutrition is defined as:

- a body mass index (BMI) of less than 18.5 kg/m²
- unintentional weight loss greater than 10% within the last 3–6 months
- a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3–6 months

Those who have eaten little or nothing for more than five days and/or are likely to eat little or nothing for five days or longer are at risk and should also be considered for nutrition support.

The contributing factors

Malnutrition is both a cause and consequence of disease and illness and there can be many contributing factors. Whilst some causes of malnutrition might be the result of underlying ill health, disease or the body’s inability to absorb nutrients, malnutrition can also be linked to other experiences or factors in a person’s life.

These include (see fig. 1) depression or anxiety, social exclusion, poor access to transport or mobility difficulties, poverty, difficulties with shopping, dental problems or the influence of medication on appetite. This list is not meant to be exhaustive but highlights many of the contributing factors. Malnutrition can be a result of one or a combination of factors.

Factors that contribute to malnutrition:

![Figure 1](image_url)
Addressing the problem

Malnutrition can be treated. Early identification and intervention is key. There is excellent clinical guidance available for the treatment of malnutrition from NICE (CG32) and the Managing Adult Nutrition in the Community pathway.

Equally, many of the social factors which can put someone at risk of malnutrition can be addressed.

This guide aims to address both the social factors which can put someone at risk of malnutrition and ensure early intervention and treatment of malnutrition in local communities.

Local health and wellbeing boards, clinical commissioning groups and local authorities need to undertake a joint strategic needs assessment to understand the scale of malnutrition in their community, care homes and hospitals. Together they must agree how malnutrition sits with competing local priorities and how addressing it can deliver a better nutritional care infrastructure that will deliver wider benefits across the community.

This guide is designed to enable local communities to transform their services and ensure the nutrition and hydration needs of older people are being met.
The case for change

Scale of the challenge

• At any given time, more than three million people in the UK are either malnourished or at risk of malnutrition

• The vast majority of these (approximately 93%) are living in the community, with a further 5% in care homes and 2% in hospitals

• It is estimated that 1 in 10 people over 65 are malnourished or at risk

• The population of people over 75 is at highest risk of malnutrition and is projected to double in the next 30 years

• As many as 33% of older people are already malnourished or at risk on admission to hospital and 37% of older people who have recently moved into care homes are at risk too

It is imperative to identify and treat people as quickly as possible. If we do not put mechanisms in place now to address malnutrition, the numbers of malnourished people and the associated human and financial costs could spiral in the future.

Consequences of malnutrition

• Research has found that individuals who are malnourished will experience: increased ill health, increased hospital admissions, increased risk of infection and antibiotic use, longer recovery time from surgery and illness and increased risk of mortality

• When compared with well-nourished people, malnourished individuals in the community saw their GP twice as often, had 3 times the number of hospital admissions and stayed in hospital more than 3 days longer

• Malnutrition in care homes has been linked to increased hospitalisation, re-admission and long term ill health
Cost of malnutrition

- Malnutrition leads to increased use of health and care services and the national estimated costs run into billions of pounds. Addressing it could lead to really significant savings.
- Severely malnourished patients identified in general practice incur additional health care costs of £1,449 per patient in the year following diagnosis.

The financial case for change

There are interventions that can demonstrate benefit and cost effectiveness.

- Fully implementing NICE guidance (see below) will result in better nourished patients, fewer hospital admissions, reduced length of stay for admitted patients and reduced demand for GPs.
- NICE identified malnutrition as the sixth largest source for NHS savings.
- Early identification and treatment of malnutrition in adults could save the NHS £13 million a year even after costs of training and screening.
- The overall resource impact of increased screening, early intervention and appropriate treatment could lead to a saving of £71,800 per 100,000 people for the average community.
- The use of oral nutritional supplements (ONS) is associated with a reduction of overall hospital re-admissions by 30%.
- Regular screening and monitoring all people in care homes has been shown to cost half the amount of treating those who are malnourished.

Note: these interventions and benefits are not solely specific to older people and cover all ages.

The levers for change

Health and Social Care Act 2008

Extract from Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

"Meeting nutritional needs:

14 — (1) Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of:

(a) a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;

(b) food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background;
(c) support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

(2) For the purposes of this regulation, “food and hydration” includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.”

Clinical guidance

• Managing Adult Malnutrition in the Community pathway
• NICE’s Nutrition support in adults (CG32)
• NICE’s Patient experience in adult NHS services (QS15)
• Nutrition support in adults (QS24) (appendix 1)

Need for action

There is evidence of good practice already but we know that some organisations need to improve nutritional care.

• The Adult Social Care Survey shows that only two thirds (64%) of older people who are receiving social care either in care homes or in their own homes say they get all the food and drink they like when they want it
• The Care Quality Commission’s (CQC) Dignity and Nutrition Inspection Programme in 2012, which inspected 500 care homes and 50 hospitals for the quality of nutritional care, found that care for older people in 17% of care homes and 12% of hospitals did not meet the required standard
• Malnutrition affects the families and carers of older people too. Research by Carers UK has found that 60% of carers worry about the nutrition of the person they care for. One in six carers are looking after someone at real risk of malnutrition but do not have nutritional support of any kind

"Organisations have to deal with so many competing priorities and may ask, 'why should we prioritise nutrition and hydration care?' The answer is simple. Without food and water, people will die."

Janine Roberts, Programme Director
Malnutrition Task Force
Best practice principles
Best practice principles

Providing best practice nutrition and hydration care revolves around five main principles.

Having gathered feedback from local authorities, health care providers, professional associations, voluntary organisations and local communities, we have identified key principles for providing good nutrition and hydration care. These are:

- **Raising awareness** to prevent and treat malnutrition and dehydration through education to older people, their families and front line staff
- **Working together** within teams, across organisational boundaries and across communities
- **Identifying malnutrition** in the individual and prevalence within organisations and across local communities
- **Personalising care, support and treatment** for every individual
- **Monitoring and evaluating** the individual and the processes in place to address malnutrition

These principles should be underpinned by a local joint commissioning strategy for good nutrition and hydration care in all settings.

Implementing these principles will require joint planning and working between health and social care commissioners and providers, the voluntary and independent sectors and representatives for older people and their carers. These principles will help build the foundations for delivering best practice nutrition and hydration care which can improve the quality of life for all people affected by malnutrition.

No matter where an older person is (in hospital, a care home or in their own home), they deserve 24 hour access to good nutrition and hydration care which can give them a better chance to live independent and fulfilling lives.

The five key principles to help prevent and treat malnutrition are applicable in all settings (hospitals, care homes and in the community).

The following diagram is based on the five principles of best practice nutritional care.
It's important to include ALL principles in your care.
Focus on improving public and professional awareness to prevent and treat malnutrition and dehydration.

Within the general public, especially older people and families, it is vital to:

- Highlight the importance of good nutrition ('why is nutrition important?')
- Point out signs and symptoms of malnutrition and dehydration ('what should I look out for?')
- Understand what can cause malnutrition and dehydration
- Offer advice on how to tackle the problem ('what can I do about it?')
- Signpost to those who can provide support ('where can I get help?')
- Identify and agree touch points within the community (see diagram below) where staff can be trained to recognise people at risk of malnutrition and dehydration
- Empower older people and carers to do what they can themselves

See the 'Engaging older people and carers' section for more details.

Train and educate staff in contact with older people. They need to:

- Know the importance of good nutrition, its impact on personal health and wellbeing of the individual ('why is nutrition important?')
- Understand the different contributing factors of malnutrition and dehydration; sometimes the solutions can be fairly simple
- Be able to identify and point out physical signs and symptoms of malnutrition ('what should I look out for?')
- Agree which staff groups should be trained to ‘assess’ someone with the tools available (such as BAPEN’s ‘MUST’ tool24)
- Know how to patiently support older people to eat and drink, particularly those

**EXAMPLE**

“A contract catering company included experience-based training for their staff. Staff experienced what it felt like to be old and this led to providing greater personal care during meal times.”
with dementia or swallowing/chewing difficulties

- Focus on working together and help everyone to know what they can and should do ('what can/should I do about it?')
- Be able to signpost older people or their carers to where they can get the right support early

**Figure 4** shows the common touch points where contact with older people in the community is likely. Raising awareness with these groups will lead to better signposting of older people to where they can get help and support.
Figure 5 shows the staff groups that may be in contact with older people in receipt of some form of care or social support.

Top Tips for Early Success
- Don’t reinvent the wheel; consider using existing information and leaflets to raise awareness. There are some examples in our resources section.
Principle 2
Working together

Principle 2 at a glance
• Work together
• Clarify roles and responsibilities
• Remove barriers

Work together and communicate clearly within and across all teams and organisations.
Individuals within organisations need to work together for an integrated approach across the community and within health care, social care, the voluntary sector, food providers and retailers.

It is important to have excellent channels of communication between health carers and other professionals, within teams providing care and support and across different organisations to ensure a seamless service and continuity of care.

Clarify roles and responsibilities at every level
It is essential that front line carers and specialist staff are clear on their roles and responsibilities (‘who needs to do what?’). Focus on:

• Agreeing who should do what, e.g. what is the role of the pharmacist, therapists and community nurses?
• Working as a team by including and consulting with older people, family and all staff from the outset
• Valuing everyone involved in the process, particularly when the solutions are a combination of clinical treatment, food solutions and/or community support
• Agree referral processes when specialist help and advice is needed, e.g. referring to the GP, dietitians or speech and language therapists

Remove all barriers to progress
• Remove barrier to progress such as internal organisational constraints, referral barriers and cross-organisational barriers created by silo working
• The Department of Health’s ‘Ready to Go’ toolkit sets out principles for transferring people between settings

Top Tips for Success
• Excellent communication is the foundation for progress.
• Value everyone involved in the process.

EXAMPLE
“Dorset LINk and Dorset County Council Health Scrutiny Committee ran a free informal session called “Let them eat cake” to encourage networking and shared learning across different care homes. 50 care home managers attended.”
Staff must be well equipped to identify malnutrition and dehydration in older people within organisations and across local communities.

There are several opportunities to identify people at risk of malnutrition.

Primary care
- When patients register with their GP, are under care for a long term condition or as part of routine health checks

Local community
- Estimate the prevalence of malnutrition in the local population using the tools available (for example, BAPEN’s resource for commissioners and providers[26])
- Assess the prevalence of malnutrition by undertaking annual screening weeks across all care settings and those in receipt of care in their own homes

At organisation level
- NICE recommends assessing individuals for risk of malnutrition on admission to care and during their time in receipt of care[6]

Identify the cause
- When someone is diagnosed with malnutrition or dehydration, identify the cause. Early diagnosis and treatment is essential for recovery. Remember that there are many different contributing factors, most of which are preventable or treatable
- Refer the person for the most appropriate support and treatment and manage as appropriate (see ‘Personalising care, support and treatment’ section)

Top Tips for Success
- Make sure all of your staff can recognise the signs of malnutrition and dehydration.
- NICE recommends the 'MUST' tool for screening.[24]
Early intervention, early treatment and a personalised plan developed with each older person and their family or carer is crucial.

There are many available solutions that work and deliver real benefits. Solutions are unique to each individual's circumstances and degree of malnutrition and dehydration. Some may require social or clinical help.

Social help includes (but is not limited to):

- Help with shopping, transport, and support with eating and drinking
- Access to meals via home delivery or lunch clubs
- Access to a positive dining experience
- Help with finances and signposting to benefits advice

Many of the social interventions can be accessed through voluntary organisations, social care, local authorities and private food or meal providers.

Treatment may include (but is not limited to):

- Food fortification
- Supplements
- Other clinical interventions prescribed by a health care professional

This guide does not intend to provide clinical guidance because there are many excellent supporting tools already available such as:

- NICE’s Nutrition support in adults (CG32)\(^6\)
- NICE’s Nutrition support in adults (QS24)\(^22\) (appendix 1)
- Managing Adult Malnutrition in the Community pathway\(^7\)

The following tools provide information on food and dining solutions:

- BDA’s ‘The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services’\(^27\)
- The National Association of Care Catering (NACC) guides\(^28\)
However, a combination of clinical treatment, food and social solutions may be required and some running in parallel, dependent upon the severity of malnutrition, may be helpful.

It is also important to look at people’s existing plans of care e.g. those with a long term condition such as a stroke, dementia, diabetes and heart disease and check to see if nutrition and hydration care has been considered!

As a minimum, it is important to:

• Ensure people have access to food and drink which meets both choice and need 24 hours a day
• Ensure that each older person has the necessary dignified support to eat and drink but also that all staff have a clear understanding of their role and are trained to help people with specialist needs, e.g. dementia
• Ensure that clinical, social care and catering teams/ meal providers teams work together with the older person and their family. Keep catering and food provider teams involved with all care plans for each older person
• Start support for ‘non’ clinical management, e.g. helping with financial or logistic difficulties, shopping or mobility problems and providing social support, activating meal delivery services or connecting people to community lunch/ meal services
• Review progress made with the individual and the team (clinical and catering) and amend the care plan as required

Create a positive and interactive dining experience. Try:

• Sociable dining times – review the most appropriate time for large meals to be served; remember to consult the individual and give them choice and control in the matter
• Creating interactive activities such as education sessions and speakers during meal times
• Ensuring food is of good quality and appealing
• Creating a restaurant style atmosphere
• Making meals the highlight of the day
• Using aromas to help stimulate appetite

A range of interactive and innovative dining solutions can be found in the resources section or the Malnutrition Task Force website.

**Top Tips for Success**

• Encourage staff to eat or have a drink with the people they care for. Meal times will be more enjoyable and staff will also experience the standard of food first hand.
Regularly monitor and review the older person’s progress and outcome.

Monitoring the processes in place will help ensure that good nutrition and hydration care is continually implemented at organisational or community level. Consider the following:

Primary care

- Monitoring and recording the weight (and risk of malnutrition) of people with long term conditions (e.g. chronic obstructive airways disease, dementia, diabetes) at the time of a routine review
- Carrying out a MUST assessment on people over the age of 75 with any acute condition with a view to developing a register of older people with a BMI of less than 20

Health care provider organisations (such as care homes and hospitals)

- Number and % of people screened on admission
- Number and % of staff trained (of those required)
- Number and % of people with weight recorded and monitored
- Number of people losing weight when it could have been prevented (unintentional weight loss)
- Number of complaints/ incidents related to poor nutritional care
- Feedback from patients and people in receipt of care
- Number of people on a personalised plan of care and progress made

Commissioners setting agreed measures as recommended by NICE in relation to:

- Numbers of people screened and monitored
- Number of staff trained
- Evidence of plans of care in place to address nutrition and hydration care
Top Tips for Success
• Don't forget to ask older people for their opinions; personal experience is equally as important as numbers.

- Commissioners can also drive providers to put additional ‘harm free care’ mechanisms in place by requesting they monitor and investigate incidents of unintentional weight loss

Adult Social Care
- Gather service user feedback on user related services and support
- Number of staff trained in nutrition and hydration care

Local health and wellbeing boards - agreeing a set of nutrition and hydration indicators such as:
- Prevalence assessments from annual screening weeks (using the tools available from BAPEN (see resources)). These will help establish whether the interventions in place are having the desired effect in the community
- They could also measure and monitor the number of admissions to hospital for issues related to malnutrition
Engaging with older people and carers
Engaging older people and carers

Improving public awareness of the personal cost of malnutrition.

We consulted older people and carers in focus groups around the country and together have developed suggestions and opportunities on how to engage with older people on the issue of malnutrition.

Raising the issue

Avoid the term ‘malnutrition’

Older people often found the term ‘malnutrition’ shocking and associated it with other negative issues such as neglect and poverty. They felt the term is not normally associated with people in the UK and could ‘switch them off’. We therefore recommend the term ‘malnutrition’ is avoided in communication with the general public. Possible alternatives include ‘undernourished’ and ‘underweight’.

The Dairy Council’s 2013 campaign to raise awareness on malnutrition includes a range of information materials that communicate clear messages yet avoid using the term ‘malnutrition’.

The materials (right) contain phrases that are easy to understand and resonate with older people, their carers and families. They offer practical advice and address particular situations such as, ‘lost your appetite?’ and ‘losing weight unintentionally?’.

The Derbyshire ‘Eat Well’ campaign leaflets have taken a similarly practical approach with visual examples.

Messages about malnutrition

Older people preferred positive messages. In testing useful messages about the effects of malnutrition, the most popular one was: ‘Eating and drinking enough is important to maintaining your health and independence’. Many thought the message, ‘People who are not eating enough take longer to recover from illness’ was useful too.

On spotting and identifying malnutrition

Older people felt the most useful messages for identifying someone at risk of malnutrition and to investigate whether someone is eating and drinking enough included: ‘They have lost weight’, ‘They look thin’ and ‘They have a poor appetite’.

It’s really important to dispel the myth that unintended weight loss is a normal part of ageing.
Communicating with carers

It’s crucial to share this advice with family members and those caring for a loved one. Carers UK found that, out of 2,000 carers providing substantial care to frail, ill and disabled people, one in four carers were looking after someone who was underweight.\(^{23}\)

More worryingly, one in six carers were looking after someone at real risk of malnutrition but were receiving no nutritional support.\(^{23}\)

Carers often report how hard it is to raise the subject and to encourage a loved one to eat and drink more.

Heléna Herklots, Chief Executive of Carers UK points out, “On top of coping with the daily stresses of caring for ill or disabled loved ones, food and nutrition can be a huge source of frustration and worry for families. Carers do their best but can often end up feeling guilty and powerless to help if older or disabled loved ones struggle to eat and get the nutrition they need. Families need support, expert advice, information and training to give them confidence as they care and peace of mind too. The research showed that good advice made all the difference to carers and improved everyone’s quality of life.”

The Carers UK survey highlighted the fact that carers are not getting the vital advice or information they need. 60% of those who responded were worried about the nutrition of the person they care for.\(^{23}\) These worries are often unaddressed because carers don’t know where to find help, receive insufficient advice and information and, at times, encounter a lack of willingness from healthcare professionals to intervene and provide support.

Conventional healthy eating messages – a challenge for those who are underweight

Conventional healthy eating messages which aim to prevent obesity and target the general public are taken on board by older people. This means that further explanations are essential when giving healthy eating advice to people who are not overweight. Therefore, any advice encouraging older people to eat high energy, high fat, high sugar or high calorie food needs explanation.

Both The Dairy Council’s and the Derbyshire ‘Eat Well’ campaigns counter this with messages such as, ‘If you are older and losing weight, most healthy eating guidelines we hear or see in the media may not apply to you.’

Most of the people we consulted agreed that messages emphasising small meals and snacks or milky drinks in between were useful advice.

Channels of communication about malnutrition

In our consultation, older people preferred human sources of information about food and eating. When asked who they would turn to if worried about weight loss or not eating enough, the most frequently mentioned sources of support were GPs, family, friends and then nurses. Those who responded to our survey suggested that invitations for a healthy weight check from the GP was the best way to engage and raise awareness amongst older people living in their own homes. Participants also said that leaflets in pharmacies, health centres or articles in their local free paper could be a useful way to distribute written information.

Please see the Malnutrition Task Force website for examples of information materials designed for older people.
Making the changes
Making the changes

We know what best practice and the underpinning principles look like.

But the question most organisations and teams face is how do we actually make this happen?

This section is dedicated entirely to the process of making the changes necessary to implement best practice. It draws upon evidence, practical experience and examples from a wide range of teams and individuals where successful and sustainable changes have been achieved.

This has been translated into key steps to help you achieve the best practice nutrition and hydration care, regardless of where you, your organisation or local community are starting from. There are plenty of excellent resources freely available to support change in the public and voluntary sector and many, but not all, are listed in our resources section.
Preparing to make the change

At a glance
- Form a powerful team

Form a powerful team

Whether you are implementing change across a community wide/strategic level or at an organisational level, addressing malnutrition requires a multi-disciplinary team approach.

The health and care system diagram below outlines the relationships between organisations.30

Figure 7
It is essential for all staff at every level and across organisations and departments to work together as much as possible to make change happen.

A community approach

A community approach will require a designated executive lead to oversee and manage the overall changes required. There should also be representation from:

- Local health and wellbeing boards
- Local hospitals
- Lead clinical commissioner or GP responsible for nutrition and hydration
- General practice
- Community nursing (lead matron)
- Dietitian and/or nutrition specialist
- Pharmacy
- Care and residential homes
- Social care providers and commissioners
- Catering service managers/providers
- Public health
- Voluntary organisations
- Large supermarket retailers* (and/or a local representative from the Association of Convenience Stores (ACS))
- Older people

Consider which stakeholders need to be kept informed about what you are trying to do and which stakeholders need to be on the team.

It is also really important during this phase to communicate to your stakeholders what you are trying to achieve and why.

* Consider involving large food providers and retailers

**Top Tips for Success**
- It is best to communicate with stakeholders verbally; relying on email is not enough.
As a local community team, you will need to agree where your services are now.

Try to find some or all of the following:

- Gather an estimate of malnutrition in the local community (for example, BAPEN’s resource for commissioners and providers)  \(^{26}\)
- Screening data of patients on admission to care homes and hospitals
- Screening or assessment data of people living in their own homes
- Existing audits or extracts of data for older people with low BMI (body mass index) or evidence of weight loss over a period of time from primary care (GP practice) information systems
- Complaints related to poor nutrition or hydration care and support
- Monitoring outcomes related to interventions (e.g. food fortification)

You could also:

- Use a Health Watch report
- Use the NICE’s Quality Standard for Nutrition support in Adults (QS24) (appendix 1)
- Use the CQC standards (appendix 2) or inspection reports of local organisations \(^{31}\)

Many of the above are negative drivers for change but you can also use:

- Examples of best practice from elsewhere
- The benefits for your team, organisation or community of implementing best practice

It is essential to be clear on the overall benefits for **all**, especially for the individual suffering from or at risk of malnutrition. It is crucial to adopt a ‘what’s in it for me to do something about it?’ approach for both staff and the individuals within their care.

All staff, irrespective of their level, need to play an active role in making changes happen and to do this they need to understand the benefits for themselves in doing so.
Develop and agree a vision of how the nutritional needs of older people should be met.

Dedicate time to run a short workshop or planning meeting for the team to agree what you do and don't do. Use this as your starting position (your baseline) and then:

- Agree a vision of what you want best practice to look like in your area
- List the areas/gaps that need changing to achieve the vision of your service
- Generate ideas, solutions and actions to achieve the changes required
- Communicate your future vision, what needs to be done to achieve it and what everyone’s specific role is in making it happen

Top Tips for Success

- Provide some protected time away to think as a team and to agree your baseline and vision. Having an executive sponsor lead and offer support can enhance this time. Consider getting an external facilitator to help you run the session.
- Consider doing an organisational raid. This means visiting somewhere that is delivering best practice or innovative ideas in nutrition and hydration care that may inspire your team.
Prioritise and implement actions in your plan.

It is very easy to come out of your planning meeting with enthusiasm and more changes than anyone can cope with. Prioritising ideas and actions will help with implementation and give people a sense that things can change and are happening. The actions and changes required can be grouped into the following:

- Those with agreement within the team and are easy to implement. These become quick wins
- Those with agreement within the team but are harder to implement. These become actions to implement over an agreed period of time

![Figure 8](image-url)

**Figure 8**

- Easy
- Important but requires time and resources
- Hard
- Set aside
- For testing in small pilots

For testing in small pilots

Important but requires time and resources

Set aside
Once you have prioritised actions, assign owners and timescales to each one. Also remember to focus on quick wins first before you start bigger and complex changes.

It is important to communicate the vision and plan to all again.

If there are changes that require more thought, are harder to do or there is uncertainty on whether they will work or not, use improvement tools such as the model for improvement available in our resources section to help you test them first (pilot) before you implement.

Before you make any changes, ensure you have a baseline measure. You can then monitor whether your changes are having a positive impact over time (e.g. the number of people screened before and after the change).

**Top Tips for Success**

- Understand your demand and capacity for specialist services such as dietetics/ nutrition services and speech and language therapists, and assess the impact any new changes may have on them.
- The Association of Nutrition has a register of Community Nutritionists.\(^{32}\)
Measuring, monitoring and embedding your changes

At a glance
• Measure your improvement
• Assess progress frequently
• Sustain the improvements

Ensure your changes are making the difference you expected and that the changes can be embedded and sustained.

It is important to be able to demonstrate and realise the benefit of the changes made.

All too often we make changes but don’t show the direct and indirect impacts and benefits of them. Regularly monitoring performance will ensure changes are sustained, the new ways of working are embedded and there is a culture change in the way things are done. Measures can be broken down into processes and outcomes.

Agree which measures will be monitored on a regular basis and by who. Set up a system for collating the right information to support this. All measures should be meaningful and reveal whether you have the right processes in place for good nutritional care. The outcomes of individual persons (or incidents across your community) must be regularly monitored too.

Track the success of changes made by measuring them against your baseline. Don’t forget to:
• Communicate progress against the measures to the wider team and across the health community
• Obtain and include user feedback (patient, resident or receiver of care) on a regular basis
• Sustain the new ways of working within the culture of the organisation or community
• Regularly assess the structures and processes in place by using the NICE standards and commissioning guides, the CQC standards or best practice principles in this guide to see if your team or organisation is providing good nutritional care

Assess your progress frequently

Once you have completed the steps, take time to reflect on your progress. The following assessment scale can help you identify your progress as a team.

1) Form a plan: A team has been formed and areas have been selected for the audits. There is an aim to improve nutritional care by focusing on best practice principles. Work on baseline measures has begun. Some teams won’t get past this stage because they
spend months trying to agree a plan.

2) **Activity but no change:** The team is actively engaged in undertaking audits and the changes needed are well understood, but work on changes to improve systems and practices has not begun.

3) **Modest improvement:** Implementing some of the changes to improve nutritional care has begun in the target areas. Initial cycles to test changes have been completed and implementation begun for some of the next key principles. There is some evidence of improvement in process measures related to the team’s aim. For example, the percentage of patients who have been screened for malnutrition has increased to 70% but there is still much improvement required to develop reliable systems.

4) **Significant progress:** Most components of the nutritional care principles have been implemented for the target population. There is evidence of real improvement in the areas measured. The nutrition steering committee and nutrition support team are set up and working well. The team is more than halfway towards accomplishing all the principles. Plans for spreading to additional areas and/or other sites have begun.

5) **Outstanding sustainable results:** The team has successfully implemented all principles. All of the team’s goals have been accomplished. Outcome measures show breakthrough improvement and are at national benchmark levels. Work to spread the model to additional areas and/or other sites is well underway.

**Sustain the improvements**

**Check how sustainable your changes are**

The sustainability tool available from the NHS improvement body is useful for assessing how sustainable your changes can be.33

**Plan for scale up and spread**

A scale up and spread strategy encourages organisations and local health communities to access and improve the areas that may have been more difficult to improve. Plan to have a roll out strategy to reach all areas and departments/care homes/community touch points to ensure that best practice is spread to and practiced by every staff member in all care settings.

**Embed improvements and changes across existing structures to ensure a sustainable future**

It is likely that you are already making improvements in raising awareness and providing best access to nutrition and hydration care, but if your experience is similar to the majority of organisations, the real challenge is to embed the improvements within your existing systems so that they are sustainable. Regular monitoring is critical to help you to achieve this.

**Celebrate success**

When you are delivering outstanding results, take time to celebrate your success. Promote and share the work you have done and the results you have achieved.

**Top Tips for Success**

• Encourage the board to sample and taste the food provided several times a year.
• Always remember to ask receivers of care for their opinion as part of measuring your success.
Appendices
Appendices

Appendix 1: NICE ‘Quality standard for nutrition support in Adults’ (QS24)

NICE has developed a ‘Quality standard for nutrition support in Adults’ (QS24). The Standards are:

Statement 1. People in care settings are screened for the risk of malnutrition using a validated screening tool.

Statement 2. People who are malnourished or at risk of malnutrition have a management care plan that aims to meet their nutritional requirements.

Statement 3. All people who are screened for the risk of malnutrition have their screening results and nutrition support goals (if applicable) documented and communicated in writing within and between settings.

Statement 4. People managing their own artificial nutrition support and/or their carers are trained to manage their nutrition delivery system and monitor their wellbeing.

Statement 5. People receiving nutrition support are offered a review of the indications, route, risks, benefits and goals of nutrition support at planned intervals.

For more information, please see:

http://www.nice.org.uk/guidance/QS24

A supporting document, ‘QS24 Nutrition support in adults: NICE support for commissioners and others’ is also available from this site.

Appendix 2: CQC Outcome 5.

Meeting nutritional needs:

14 — (1) Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of:

(a) a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users’ needs;

(b) food and hydration that meet any reasonable requirements arising from a service user’s religious or cultural background;

(c) support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

(2) For the purposes of this regulation, “food and hydration” includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.”

Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010


For more information, see ‘Essential Standards of Quality and Safety’

http://www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-meeting-standards
References

1 M. Elia, R. M. Smith, Improving Nutritional Care and Treatment: Perspectives and Recommendations from Population Groups, Patients and Carers, BAPEN, 2009

2 Robert Francis (chair), The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013

3 Available at: http://www.telegraph.co.uk/health/healthnews/9850323/Starved-pensioner-left-without-care-dies.html

4 Available at: http://www.cqc.org.uk/public/reportssurveysandreviews/themedinspections/dignityandnutritionolderpeople


6 Nutrition Support in Adults (CG32), NICE, 2006

7 Available at: http://malnutritionpathway.co.uk

8 Malnutrition in Older People in the Community: Policy Recommendations for Change, European Nutrition for Health Alliance, BAPEN and ILC-UK, 2006

9 National Population Projections, 2010-Based Projections, Office for National Statistics, 2011

10 Calculation based on BAPEN Screening weeks 2007-11


12 M. Elia et al, The cost of disease related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults, BAPEN, 2005


14 J. F. Guest et al, 'Health economic impact of managing patients following a community-based diagnosis of malnutrition in the UK', Clinical Nutrition, 2011, 30, 4


16 Benefits of Implementation: Cost saving guidance, NICE, (updated) 2013

17 National cost impact report to accompany CG32, NICE, 2006

18 NICE support for commissioners and others using the quality standard on nutrition support in adults, NICE, 2012


20 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

21 Patient Experience in Adult NHS Services (QS15), NICE, 2012

22 Nutrition Support in Adults (QS24), NICE, 2012

23 Malnutrition and Caring: The Hidden Cost for Families, Carers UK, 2012

24 Available at: http://www.bapen.org.uk/screening-for-malnutrition/must/must-toolkit/the-must-itself
25 Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care, Department of Health, 2010

26 Malnutrition Matters: Meeting Quality Standards in Nutritional Care, A Toolkit for Commissioners and Providers in England, BAPEN, 2010

27 The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services, The British Dietetic Association, 2012

28 Available at: http://www.thenacc.co.uk/shop/Goodpracticeguides

29 Available at: http://malnutritiontaskforce.org.uk/downloads/integrated_working/Derbyshire_Eat_Well_Leaflets_1.pdf

30 Available at: http://healthandcare.dh.gov.uk/system

31 Available at: http://www.cqc.org.uk/public/reports-surveys-and-reviews

32 Available at: http://www.associationfornutrition.org/

33 Available at: http://www.institute.nhs.uk/
Resources

Age UK
www.ageuk.org.uk

Alzheimer’s Society
www.alzheimers.org.uk

Association for Nutrition
wwwassociationfornutrition.org

BAPEN
1) Organising food and nutritional support in hospitals: an interactive diagram to demonstrate how nutritional services might link within a hospital
www.bapen.org.uk/ofns/index.html

2) Education and training: interactive e-learning modules on nutritional screening using ‘MUST’ for hospitals and community
www.bapen.org.uk/screening-for-malnutrition/must/must-toolkit/e-learning-resources-on-nutritional-screening-for-hospitals-and-the-community

3) ‘Malnutrition Matters: Meeting Quality Standards in Nutritional Care’, A Toolkit for Commissioners and Providers in England
www.bapen.org.uk/pdfs/toolkit-for-commissioners.pdf

4) MUST toolkit
www.bapen.org.uk/screening-for-malnutrition/must/must-toolkit/the-must-itself

British Dietetic Association (BDA) ‘Mind the Hunger Gap’ resources
www.mindthehungergap.com

British Dietetic Association (BDA) Nutrition and Hydration Digest
www.bda.uk.com/publications/NutritionHydrationDigest.pdf

Carers UK
www.carersuk.org

Caroline Walker Trust
www.cwt.org.uk

Care Quality Commission Domain 5 Standard
www.cqc.org.uk

CQC Dignity and Nutrition Inspections 2011:

CQC Dignity and Nutrition Inspections 2012:

The Dairy Council
www.milk.co.uk

Hospital Caterers Association (HCA)
www.hospitalcaterers.org

Managing Adult Malnutrition in the Community pathway
www.malnutritionpathway.co.uk

My Home Life
www.myhomelife.org.uk

National Association of Care Catering (NACC)
www.thenacc.co.uk

National patient safety agency
www.npsa.nhs.uk

10 key characteristics of good nutritional care
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59865

NHS resource to help make changes
www.changemodel.nhs.uk/pg/dashboard

NHS resource of improvement tools
www.institute.nhs.uk/quality_and_service_improvement_tools/

NICE Nutrition support in adults (CG32)
www.nice.org.uk/CG32

NICE Nutrition support in adults (QS24)
www.publications.nice.org.uk/quality-standard-for-nutrition-support-in-adults qs24

NICE Patient experience in adult NHS services (QS15)
www.guidance.nice.org.uk/QS15

‘Ready to Go?’ discharge guide,
Department of Health
http://ow.ly/khXL7

Royal College of Nursing
www.rcn.org.uk

Royal Society of Public Health: Eating for health in residential care homes

Salvation Army
www.salvationarmy.org.uk/

SCIE - Dignity in Care
http://www.scie.org.uk/

Women’s institute
http://www.thewi.org.uk/

WRVS
http://www.wrvs.org.uk/

Please see the Malnutrition Task Force resources page for full details of the examples featured in this guide.