

4th
EDITION



Managing Adult Malnutrition in the Community

A guide to managing disease-related malnutrition, including a pathway
for the appropriate use of Oral Nutritional Supplements (ONS)

Produced by a multi-professional consensus panel

malnutritionpathway.co.uk

The Malnutrition Pathway Community Interest Company (C.I.C.)



The Primary Care Society
for Gastroenterology



Endorsed by
**ROYAL
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Introduction

This document is a practical guide to support healthcare professionals in the community to **identify and manage** individuals at risk of malnutrition, particularly **disease-related malnutrition**, including the appropriate use of oral nutritional supplements (ONS). It has been written and agreed by a multi-professional consensus panel with expertise and an interest in malnutrition, representing their respective professional associations. Members of the public were involved in developing the patient/carer resources.

The aim of this document is to:

- Assist healthcare professionals to optimise patient outcomes through good nutritional care in settings outside of hospital e.g. primary care practice, care homes, outpatient clinics
- Address inappropriate prescribing whilst at the same time ensuring we are identifying those most at risk of malnutrition
- Raise awareness of key patient groups who are at particular risk of malnutrition and likely to benefit from intervention
- Reduce the additional health and social care costs associated with untreated malnutrition through early identification, timely treatment and effective prevention strategies
- Bring together the evidence on diet, food fortification and the appropriate use of oral nutritional supplements to present practical messages that support the development of local guidance and help implement national recommendations

Topics covered:

- Disease-related malnutrition
- How to undertake nutritional screening to identify malnutrition and subsequent assessment of those at risk
- Management according to underlying causes and level of malnutrition risk
- Evidence-based pathway to guide the use of ONS

Topics not covered:

- Malnutrition arising solely from socio-economic or environmental issues
- Parenteral nutrition
- Enteral tube feeding
- Acute hospital setting
- Paediatrics (patients under 18 years of age)
- Eating disorders

This document is based on clinical evidence, clinical experience and accepted best practice. It has been developed for use across the United Kingdom (England, Northern Ireland, Scotland and Wales). While elements may be relevant to other countries, recommendations are based on UK policy, practice and guidance.

Local guidance may be available; contact your local Nutrition and Dietetic services for further information or refer to your local formulary.

The Malnutrition Pathway C.I.C. also provides specific guidance on a number of other specific areas including:

- Chronic Obstructive Pulmonary Disease (COPD) - 'Managing Malnutrition in COPD' (malnutritionpathway.co.uk/copd)
- Managing Frailty, Sarcopenia and Malnutrition (malnutritionpathway.co.uk/frailty_guide)
- Optimising Nutritional Care in Cancer (malnutritionpathway.co.uk/cancer)
- Dysphagia (malnutritionpathway.co.uk/dysphagia.pdf)
- Falls - Integrating Nutrition into Falls Pathways (malnutritionpathway.co.uk/falls.pdf)
- Care Home Residents (malnutritionpathway.co.uk/carehomes)
- Sarcopenia (malnutritionpathway.co.uk/library/factsheet_sarcopenia.pdf)

Overview of Malnutrition

Malnutrition is defined as an excess or a deficiency of energy, protein and other nutrients that causes adverse effects on the body (shape, size and composition), the way it functions and clinical outcomes¹. Malnutrition can be disease-related or caused by social factors. **In this document the term malnutrition refers to undernutrition relating to, or caused by, disease.** Disease-related malnutrition can be challenging to manage due to the effects of the disease and associated treatments and may require multimodal treatment². This is in contrast to social malnutrition arising from economic and environmental factors (e.g. poverty, isolation, poor mobility or self-neglect), where the provision of adequate food and drink can result in the reversal of malnutrition. It should be noted that in some cases of disease-related malnutrition social factors may also play a part. It should also be noted that it is possible for those who are overweight/obese to be malnourished and in such cases attention should be paid to unexplained weight loss.

Size of the problem

At any point in time more than 3 million people in the UK are malnourished or at risk of malnutrition. Most of these (~93%) live in the community³. The 2023 National Nutrition Screening Week data shows rising incidence across care settings, yet fewer patients have care plans in place.

Malnutrition (undernutrition) affects:

- 47% in hospitals⁴
- 42% in care homes⁴
- 50% in rehab/community hospitals⁴
- 56% in mental health units⁴
- 11% of people visiting general practice⁵

Clinical consequences of malnutrition

- Reduced muscle strength⁶ and frailty^{7,8}
- Increased risk of falls^{9,10}
- Slower recovery from illness and surgery⁶
- Poorer clinical outcomes e.g. higher mortality⁶
- Impaired psycho-social function⁶ (e.g. anxiety, depression, altered cognition)
- Impaired immune response⁶
- Impaired wound healing⁶

This document aims to support healthcare professionals in delivering proactive nutritional care by highlighting opportunities across diverse settings for multi-disciplinary teams to identify, manage, and review patients at risk of malnutrition.

Cost Implications of Malnutrition



Malnutrition costs in excess of £23.5 billion per annum in the UK, based on malnutrition prevalence figures and the associated costs of both health and social care¹². It is estimated that the cost of health and social care for a malnourished individual is three times greater than for a non-malnourished individual¹¹:

Estimated Annual Cost	Non-malnourished individual	Malnourished individual
Healthcare	£1,715	£5,763
Social care	£440	£1,645
TOTAL	£2,155	£7,408

Tackling malnutrition can improve nutritional status, clinical outcomes, reduce health care use and associated healthcare costs¹³.

- Patient centred consultations and interventions can improve quality of life¹³
- Effectively managing malnutrition can bring about significant cost savings^{11, 14-16} of at least £123,530 per 100,000 by managing individuals at risk of malnutrition according to the National Institute for Health and Care Excellence (NICE) guidance¹²
- Nutrition support products (ONS, tube feeds and parenteral nutrition) costs are low at <2.5% of the total expenditure on malnutrition¹²

Groups at risk of malnutrition

Chronic conditions: Respiratory conditions (such as COPD and interstitial lung disease), cancer, gastrointestinal disease, renal or liver disease, rheumatoid arthritis, heart failure, inflammatory bowel disease (IBD)^{3, 6, 17}. Consider acute episodes and exacerbations.

Progressive neurological disease³ e.g. dementia, Parkinson's disease, stroke, motor neurone disease (MND), those with cognitive decline

Acute illness³: where adequate food is not consumed for more than 5 days

Frailty and falls⁶ e.g. immobility, old age, recent discharge from hospital and sarcopenia (including sarcopenia in both frail and obese patients)

Prehabilitation¹⁸: to optimise nutritional status prior to surgery

Rehabilitation: to provide on-going support in the community after an acute episode of care e.g. after surgery¹⁹, stroke³, injury⁶, cancer treatment⁶, hospital admission¹¹, an episode involving intensive care²⁰

Neuro-disability e.g. cerebral palsy^{21, 22}, learning disabilities^{23, 24}

End of Life/Palliative Care^{25, 26}: tailor and adjust advice according to phase of illness, maintenance of patient comfort and respect of choice, particularly towards the end of life. (see www.rcp.ac.uk/media/fw5pmtvw/supporting-people-who-have-eating-and-drinking-difficulties_3_0.pdf)

People with impaired swallow (dysphagia)²⁷

Individuals with mental health challenges and other vulnerable adults: pay particular attention to safeguarding concerns²⁸

NB: Patients with socio-economic and environmental issues i.e. with little or no support, who are housebound or who experience difficulty accessing/preparing food, are at increased risk of malnutrition³. This risk may be further compounded if disease-related malnutrition is also present.

Four Steps to Managing Malnutrition including Unintentional Weight Loss

The process of managing disease-related malnutrition can be broken down into four key steps:

Step 1: Identification of malnutrition: nutrition screening

Step 2: Assessment: identifying the underlying causes of malnutrition, including those which can be addressed/reversed

Step 3: Management: identifying treatment goals and optimising nutritional intake

Step 4: Monitoring the intervention

Step 1: Identification of Malnutrition: Nutrition Screening

Identify malnutrition by using a validated screening tool e.g. the 'Malnutrition Universal Screening Tool' ('MUST')¹ - bapen.org.uk/pdfs/must/must_full.pdf

When to screen

- **Opportunistically** - on first contact within a new care setting e.g. upon registration with GP, outpatient appointment, on admission to a hospital or care setting^{29,30}, contact with Community/District Nurse, during pharmacist-led medication reviews (particularly for individuals on polypharmacy), during annual disease reviews, pre-operative assessments, specialist community clinics for 'at-risk' groups (see page 3), and at dental appointments.
- **Upon clinical concern** - examples include: unplanned weight loss, loose fitting clothes, appearing thin, fragile skin, poor wound healing, pressure ulcers, apathy, muscle wasting (sarcopenia, including in overweight individuals), reduced physical function, frequent falls, recurrent infections, poor appetite, altered taste sensation, difficulty swallowing or chewing, altered bowel habit or gut function, prolonged intercurrent illness, before, during and after surgery or cancer treatment, chronic or deteriorating medical conditions or side effects to medicines.

Screening frequency

Once an individual has been identified as at risk of malnutrition, further assessment, treatment and repeat screening are recommended to evaluate improvement, deterioration and the need for further action²⁹ (see page 8). Frequency of screening will depend on the individual and their requirements, progress, needs and treatment goals (see page 5) and should reflect local and national policy and guidance.

Step 2: Assessment: Identifying the Underlying Causes of Malnutrition

Identifying the underlying causes and contributory factors is key to help determine the most appropriate nutritional care. Remember that some treatments and medications can have side effects which can impact on nutritional status, eating and drinking. Dietary advice leaflets on managing diet-related problems/symptoms that are interfering with food intake can be found at malnutritionpathway.co.uk/leaflets-patients-and-carers and may also available from local dietetic departments. In some cases referral to a dietitian/nutrition support team may be required.

Below are some examples of factors that can interfere with eating and drinking and ideas on actions and dietary modifications that may help:

Examples of problems/symptoms	Considerations	
Early satiety, reduced appetite, feeling full after small amounts	Eating nutrient dense/nutritious foods, little and often, e.g. high calorie/energy, high protein foods	Consider if any medications are causing or aggravating symptoms and whether they can be stopped or if alternative medicines/treatments may help - seek advice from a Pharmacist
Dry mouth, sore mouth, fatigue, chewing difficulties	Soft, easy to chew, moist diet with added sauces. Consider if issues are caused by external factors e.g. poor dentition, oral thrush, and refer as appropriate	
Loss of taste, taste changes	Enhance taste with sauces, marinating, trying new foods, adding herbs, spices or zest	
Difficulty swallowing	Consider referral to a Speech and Language Therapist, see also the advice on managing dysphagia - malnutritionpathway.co.uk/dysphagia.pdf	
Change in bowel habit, vomiting	Check for causes e.g. disease, side effects of treatment, infection - seek further advice on treatment, consider referral to a Dietitian	
Pain	Identify cause, seek advice on management and suitable medication	
Anxiety, depression	Under nutrition can be a cause and a consequence of anxiety or depression. Consider referral to other services where appropriate	

NB: In all cases consider whether dietary modifications will be enough to improve dietary intake

Step 3: Management of Disease Related Malnutrition

Management of malnutrition should be individualised and linked to the level of malnutrition risk (see page 8). In many cases malnutrition can be managed using dietary advice to optimise food intake with oral nutritional supplements (ONS) being used when food intake has been demonstrated to be insufficient, or when it is anticipated food alone will not meet nutritional requirements³¹. All patients at risk of malnutrition

should have a care plan, where applicable this should link to their overall disease management pathway. Consider how nutrition screening and the Malnutrition Pathway resources, might be embedded into existing care pathways to trigger early action in conditions that pose a high risk of malnutrition e.g. COPD, frailty, cancer. Collaborating with local Dietitians or other specialists can help embed the principles of the Malnutrition Pathway into disease pathways, ensuring a more integrated approach to nutritional support.

Members of the **multidisciplinary team** who may help determine and deliver the optimal nutritional strategy for the patient.

GP	Dietitian	Nurse	Consultant/Specialist
Occupational Therapist	Physiotherapist	Speech and Language Therapist	Physician Associates
Practice Pharmacist	Community Pharmacist	Social Prescriber	Assistant Practitioners

Appointing a Nutrition Champion from the MDT team can facilitate the integration of optimal nutritional care, thereby improving patient outcomes.

Identifying Treatment Goals

Agreeing realistic goals with the patient and carers, should be an integral component of management. When setting goals, it is important to consider disease stage and treatment. The table below outlines some examples of goals to consider in a range of medical conditions:

Goals to consider	Examples by medical condition
Optimise recovery, promote healing	Pressure ulcer treatment and post-surgery/discharge
Optimise response and tolerance to treatment	Patients with cancer
Improve mobility and reduce risk of falls	Frailty in older people
Prevent further weight loss and preserve function	Palliative care
Improve strength/increase muscle mass	Patients with sarcopenia or sarcopenic obesity
Increase nutritional status and promote weight gain	Any patient with disease-related eating difficulties
Improve quality of life or ability to undertake activities of daily living	Frailty, rehabilitation
Reduce the risk of exacerbations or respiratory infections	COPD
Reduce severity of disease	IBD
Improve/restore function	Post stroke, post intensive care episode
Slow deterioration in physical and mental function	MND, Parkinson's disease, cognitive decline
Reduce hospital admissions and length of stay	Applicable to a range of conditions

Optimising Nutrition and Hydration

Oral nutritional support can comprise some or all of the following: fortifying food and fluids with protein, carbohydrate and/or fat, vitamin and mineral supplementation, the use of snacks, nourishing drinks and/or oral nutritional supplements in addition to regular meals; changing meal patterns; practical measures such as assistance with eating, shopping (physical and financial) and preparation of food; texture modification²⁹. The intervention and goals should be determined through a thorough assessment and an understanding of what is feasible, acceptable and practical to the patient and carers.

When **determining the intervention** it is important to note that the disease itself along with associated treatments (including medications), can cause physiological changes that suppress appetite, reduce the desire to eat, trigger early satiety (a feeling of fullness after a small amount of food), affect taste and alter metabolism which in turn alters body composition (such as muscle mass). These effects may limit the effectiveness of a food-only approach and the use of ONS may need to be considered earlier in the management pathway to avoid unnecessary deterioration and minimise any loss of muscle and function that may be irreversible. Taking into account the trajectory of the disease i.e. is it curative or palliative is important to guide how assertive the intervention should be³². Educating the patient and carer on the likely benefits and managing expectations on what can be realistically achieved are also crucial components of care.

Dietary advice to optimise nutritional intake

- Encourage small, frequent meals and snacks with a focus on nutrient-dense foods and drinks
- Talk with individuals about their attitudes, concerns, habits, and preferences around eating and drinking. See helpful hints on how to do this at malnutritionpathway.co.uk/pcn/pcn_library/weight_diet_conversations.pdf
- Care should be taken when fortifying food and drink to ensure nutritional requirements, including protein and micronutrients are met.²⁹ Avoid relying on high-fat options alone. A multivitamin and mineral supplement may be helpful if diet variety or intake is limited
- Advise on increasing energy and protein intake by prioritising nutrient-dense foods and higher-calorie options, (e.g. fortify fluids with ingredients like milk powder or ground nuts) to boost nutritional value without added volume
- Provide the yellow leaflet 'Your Guide to Making the Most of Your Food' and advice on issues like taste changes. Leaflets are available at malnutritionpathway.co.uk/leaflets-patients-and-carers and may also be available from your local nutrition and dietetic team
- For individuals following a plant-based diet, the 'Plant-Based Eatwell Guide' and fact sheets on high-protein options and healthy weight gain strategies are available at plantbasedhealthprofessionals.com
- Dietary restrictions e.g. low fat, low sugar previously advised upon to manage co-morbidities (e.g. diabetes, cardiovascular disease) may need to be relaxed to increase the energy (Calorie) content of the diet particularly when appetite is poor. Dietitians are skilled at providing dietary counselling: if in doubt about the suitability of dietary advice because the patient has a number of medical conditions that require dietary modification, seek input from a Dietitian
- Group education sessions for individuals with long-term conditions can support nutritional self-management, facilitate peer exchange of ideas and help activate change

Always advise on adequate hydration as it is vital to support bodily functions and help the bowels and kidneys work well

The Malnutrition Pathway website includes some practical case studies to illustrate how to put the pathway into practice and the impact of selected nutrition interventions according to an individual's needs: malnutritionpathway.co.uk/case-studies

The Importance of Protein

Multiple studies show that older adults and those who are unwell require 25–30g of high-quality protein at each meal to build or maintain muscle effectively^{33,36}. During illness and ageing, protein intake is often inadequate^{37,38}. If left unaddressed, this shortfall - alongside insufficient energy intake - can lead to muscle loss, reduced immunity and strength, and difficulty performing everyday tasks³⁷. These effects can hamper recovery, increase the risk of falls, dependency on others and mortality³⁹.

- Patients should be encouraged to consume 3–4 portions of high-protein foods daily
- For individuals with sarcopenia (loss of muscle mass and strength) or sarcopenic obesity, it is important to emphasise protein-rich foods and drinks alongside resistance exercises to support gains in lean muscle mass. In sarcopenic obesity, the goal is typically weight maintenance, not weight gain. Further information is available at malnutritionpathway.co.uk/sarcopenia
- Not all protein sources are equal: high-quality options provide essential amino acids that support muscle and overall health, while lower-quality sources may have limited amino acids and require care in combining to make the protein in the diet more complete

For ideas and practical guidance on adding protein rich foods to the diet visit malnutritionpathway.co.uk/proteinfoods

Oral nutritional supplements (ONS) to optimise oral intake

- ONS are typically used to supplement the diet when diet alone is insufficient to meet daily nutritional requirements. They are not intended as a food replacement but rather to increase overall nutritional intake without displacing normal food consumption⁴⁰
- Patient education, combined with early assertive nutrition support and advice on resistance activity may achieve the best outcomes in those with limited intake, poor appetite and disease-related malnutrition⁴¹
- ONS should be given in accordance with an evidence-based pathway (see pages 8 and 9). Their use should be regularly reviewed
- Serving method and timing can influence adherence - ONS are best consumed at a time when the patient feels most comfortable, such as between meals, as split doses e.g. 40 ml doses regularly across the day, first thing in the morning, or before bed. Serving ONS chilled or blending it with flavouring agents such as coffee, mixing into jellies, soups, or sauces can be considered to enhance acceptability⁴²
- Multimorbidity is a key driver of malnutrition. Advice to adapt food intake might represent a significant burden to people who are ill and their carers. ONS may therefore be needed to help such individuals meet their nutritional needs^{40,43}

The Evidence

- NICE CG32 recommends considering oral nutrition support to improve nutritional intake for people who can swallow safely and are malnourished or at risk of malnutrition (based on high quality/A-grade evidence)²⁹
- NICE QS24 emphasises the need for all care services to take responsibility for the identification of people at risk of malnutrition, to provide nutritional support for everyone who needs it and to take an integrated approach to the provision of services³⁰

Clinical studies, systematic reviews and meta-analysis in malnourished patients, demonstrate that ONS:

- Increase energy, protein, and micronutrient intake, contributing to improved nutritional status^{29,40,44}
- Do not suppress voluntary food intake when timed appropriately^{13,44}
- Improve weight and functional benefits (e.g. improved hand grip strength and quality of life)^{13,29,44-48}
- Are a clinically and cost-effective way to manage malnutrition in the community particularly amongst those with a low body mass index (BMI) (BMI < 20 kg/m²) and those with a 'MUST' score of 2 or more^{29,46-51}
- Contribute to reducing healthcare costs through reductions in pressure ulcers, poor wound healing, infections^{43,46}, hospital admissions and readmissions^{46,48-50}
- Clinical benefits in the community are achieved with 300-900kcal/day (1-3 ONS servings per day) typically with 2-3 months' supplementation^{29,44,46}. Supplementation periods may be shorter, or longer (up to 1 year) according to clinical need
- Clinical benefits of ONS are presumed due to the increased multi-nutrient intake. If a similar increase in nutrient intake can be achieved by dietary means alone, it is reasonable to expect similar clinical benefits. In those who are unwell, at high risk of malnutrition and with eating difficulties, it should be born in mind that it may not be possible nor feasible to modify and rely on food intake alone to achieve the desired nutrient increases and hence a multimodal approach utilising ONS in combination with support and dietary counselling from a suitably skilled professional e.g. Dietitian, to optimise intake may be needed^{16,32,40,43}

NB: Most clinical studies used ready-to-drink ONS. Currently there is limited evidence to confirm whether powered ONS yield comparable outcomes to those listed in the evidence section above.

Choosing the Appropriate Oral Nutritional Supplement (ONS)

A wide range of ONS are available to meet individual needs and preferences. These vary in style (e.g. milk, juice, yogurt, savoury), format (liquid, powder, pudding, pre-thickened), energy density (typically 1-2.4kcal/mL), and flavour. Selection should be guided by clinical judgement and local prescribing policies. Key types of ONS include:

Standard ONS: Typically provide ~300kcal, 12g of protein, and a full range of vitamins and minerals per serving⁵². Most individuals requiring ONS can be managed with products providing 1.5–2.4kcal/mL. Plant-based ONS are now widely available; while some may differ in nutritional content compared to traditional formulations, many are designed to provide comparable energy and protein levels.

High-protein ONS: Suitable for individuals with increased protein needs, such as those with COPD, wounds, post-operative recovery, cancers, frailty, sarcopenia, or post-ICU. N.B.: European expert consensus recommends that ONS for older adults provide at least 30g of protein and 400kcal per day⁵³ (this recommended intake would typically be delivered through 2 bottles daily of a high-protein, low-volume ONS).

Low-volume, high-energy ONS: May aid adherence^{54,55} and be better tolerated by individuals who struggle with larger volumes, such as those with breathlessness e.g. COPD or very limited appetites due to illness (125ml compact bottle is typically 2-2.4kcal/ml).

Commencing ONS and Assessing Adherence

Adherence to ONS is important to achieving intended clinical outcomes. Before recommending a product, it's important to consider patient preferences, practical capabilities, and whether they can prepare, access, and consume the supplement as intended.

Selecting the Most Appropriate Product

- When choosing an ONS, consider clinical, practical, and social factors that may influence adherence. These may include: nutritional content and volume, dietary preferences (e.g. plant-based), the presence of diabetes (consider small doses over time and adjustment to medication), renal function, cost and affordability, palatability and the ability to open or mix the product.
- Additional guidance on product types, including fibre-containing ONS (for gastrointestinal support), and pre-thickened or pudding-style ONS (for individuals with dysphagia - to be used with Speech and Language Therapist input), is available on the Malnutrition Pathway website at malnutritionpathway.co.uk/library/ons.pdf

Assessing Feasibility of Powdered ONS

- Before recommending powdered ONS to patients, consider the following⁵⁶:
 - i Does the patient or carer have the physical ability to make up powdered ONS as directed on the package and to ensure safe handling practice?
 - ii Does the patient have access to both a fridge and fresh milk and have adequate storage for milk and boxes of powder?

If concerns arise regarding points i or ii, a ready-to-drink ONS may be more suitable. These considerations also apply to self-purchased powdered ONS, which are available in supermarkets, pharmacies, and online.

Supporting Adherence

- Test preferences and adherence with a 'starter pack' which offers a range of products/flavours (free from manufacturers; prescribe once only). Aim to establish preferred flavours, likes and dislikes e.g. milk or juice, sweet or savoury
- Once preferences are established (e.g. preferred product/flavour), prescribe 1-3 ONS per day (e.g. 2 ONS per day between meals), reviewed at least monthly (see pathway on page 9 for guidance)^{29, 44-46, 49}
- Always issue ONS with clear instructions (e.g. one to be taken twice a day between meals for one month until review) to support adherence and manage expectations
- Add a review date on repeat prescriptions to assess ongoing need and evaluate adherence. If adherence is poor, explore reasons and refer to a Dietitian or other healthcare professional if appropriate

Clinical Context and Ongoing Review

- Acute and chronic disease may adversely affect appetite and the ability to source, prepare, or consume meals and drinks. Dietary advice and ONS are only effective if feasible, acceptable, and acted upon. Support patients and families to understand the role of nutrition, and maintain regular communication to assess and reset goals as needed
- A Dietitian may request a specific product based on assessment. Should there be a reason or desire to amend the prescription e.g. it is not included in the local formulary, the rationale for the specific product recommended should be sought as multiple factors are likely to have guided decision-making regarding the most suitable ONS

Individuals Requiring Specialist Dietetic Support

The following individuals may need specialist dietetic input to ensure safe and appropriate intake tailored to clinical needs:

- Those with protein restrictions, renal impairment, poorly controlled diabetes or other dietary restrictions (e.g. potassium, phosphate)
- Individuals with food allergies, intolerances or malabsorption (e.g. lactose)
- Patients requiring ONS as a sole source of nutrition or modular ONS (providing only one or two nutrients)

Patients Discharged from Hospital on ONS

- Follow dietetic advice given in the discharge summary or any correspondence
- If ONS have been initiated in hospital but the patient was not reviewed by a Dietitian or no follow-on advice is provided, it is suggested that the patient is reassessed following the management pathway on page 8. Particular attention should be given to patients in 'at risk' groups as outlined on page 3

Advisory Committee for Borderline Substances (ACBS) indications for prescribing standard ONS

- ONS should be used in accordance with their indications for prescribing only, such as for the dietary management of disease related malnutrition
- The ACBS approved indications for all ONS can be viewed at nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff
- Healthcare professionals should also refer to their local formularies for guidance
- There may be individuals who fall outside these criteria, but who you think, based on clinical judgement, may benefit from ONS – for example someone with a new diagnosis who is starting to lose weight but does not yet reach the 'MUST' criteria for risk of malnutrition

If prescribing for someone who does not meet the ACBS criteria, take care to document the rationale for ONS.

N.B.: There are individuals for whom ONS might not be appropriate e.g. in substance misuse - clinical judgement should be used.

Step 4: Monitoring the Intervention

Monitor progress against goals and modify intervention appropriately, maintain communication channels and adjust care plan according to patient feedback:

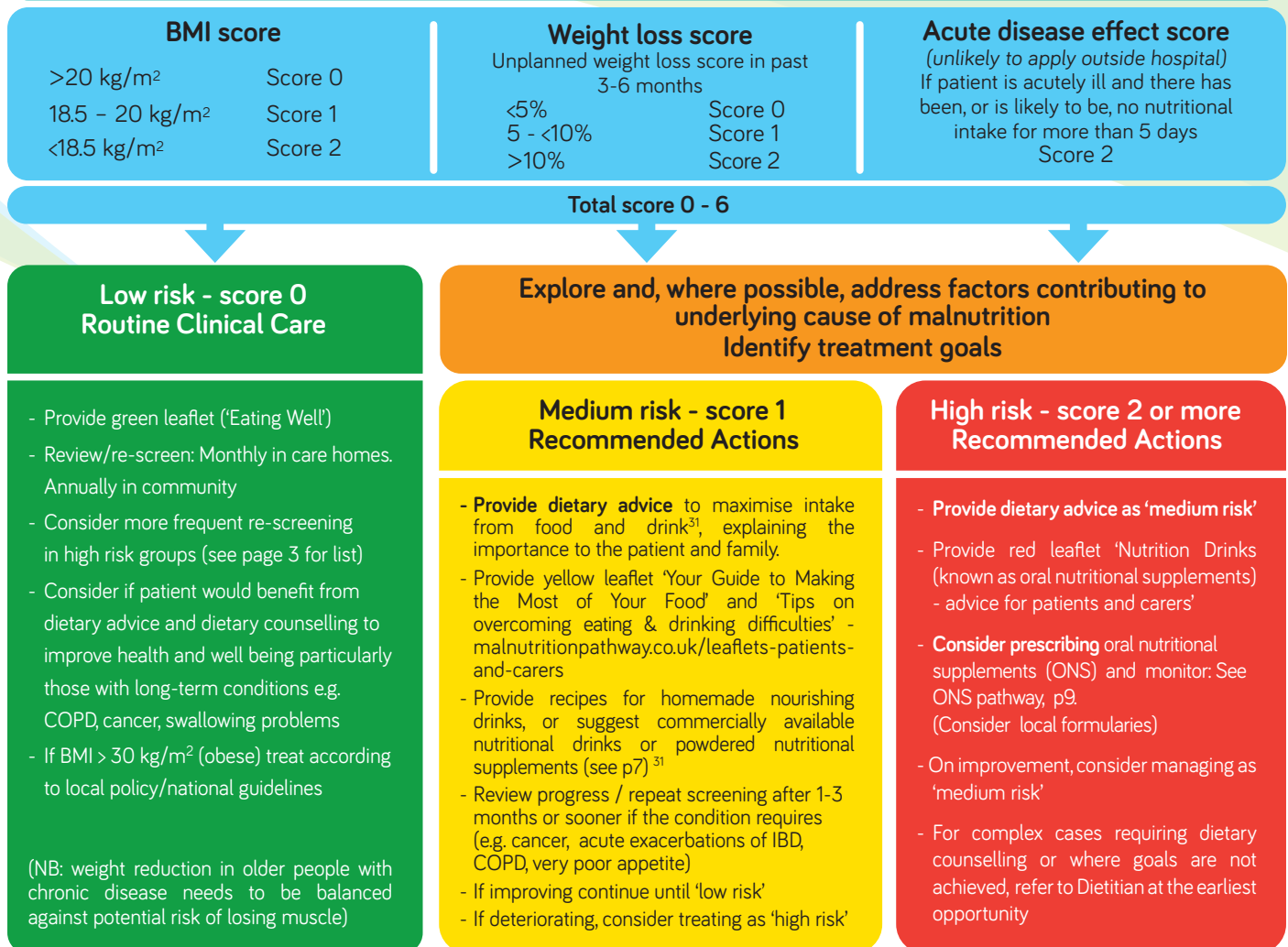
- Consider weight, strength, physical appearance, mood, appetite, ability to perform activities of daily living and compare with the goals originally set

Frequency of monitoring depends on nutritional status of patient (p. 8 & 9), care setting, treatment, disease prognosis and organisational policy.

Discontinuing ONS

After the initial prescription, the need for ONS should be reviewed. Discontinue ONS when **adequate oral intake is established, goals/targets are achieved and the individual is stable**²⁹ and no longer at risk of malnutrition. Continue to monitor/make regular assessment of progress to check individual remains stable (consider relapsing conditions e.g. COPD, IBD).

Managing Malnutrition According to Risk Category using 'MUST'*¹ – Management Pathway



If consultations are being undertaken remotely without physical measures (e.g. BMI, weight)¹:

- use patient reported values of current weight, height, and previous weight to calculate Step 1 and Step 2 of 'MUST' if available
- where it is not possible to obtain physical or self-reported measures of weight or height (measured or recalled) a range of subjective indicators can be used collectively to estimate malnutrition¹ (see below)
- patients can also be encouraged to self screen using malnutritionselfscreening.org

The following questions or the Patients Association checklist (bit.ly/3HFAY88) can assist in obtaining information to inform a clinical impression of malnutrition risk and help to determine the most appropriate intervention:

1. How is your appetite lately? How are you managing with your eating and drinking?
2. How would you describe your weight? What is a usual weight for you?
3. Do you feel like your weight has changed in the last few weeks or months?
4. How are your clothes and jewellery fitting? Do they feel like they fit differently to usual?

Estimated risk of malnutrition	Indicators
Unlikely to be at-risk (low)	Weight stable or increasing, no unplanned weight loss, no reduction in appetite or intake
Possibly at-risk (medium)	Unplanned weight loss as a result of disease/condition in previous 3-6 months, reduced appetite and/or ability to eat
Likely to be at-risk (high)	Significant unplanned weight loss in previous 3-6 months, reduced appetite/ability to eat/dietary intake and/or visibly very thin

For all individuals:

- Discuss when to seek help e.g. ongoing unplanned weight loss, changes to body shape, strength or appetite. Don't overlook individuals with a high BMI in whom malnutrition arising from impaired intake and weight loss may not be obvious e.g. post-surgery, cancer, COPD
- Ensure that care plans are communicated between care settings³⁰
- Refer to other healthcare professionals (HCPs) if additional support is required (e.g. Dietitian, Physiotherapist, GP, Speech and Language Therapist)

*The 'Malnutrition Universal Screening Tool' ('MUST') is used here with the permission of BAPEN (British Association for Parenteral and Enteral Nutrition)

Pathway for using Oral Nutritional Supplements (ONS) in the Management of Malnutrition

NB: timing and duration will vary depending on appetite and nutritional requirements – this is a guide based on evidence and best practice.

Individual identified as high risk (page 8)

Chronic Conditions (e.g. COPD, Cancer, Frailty) /Acute Illness/Recent Hospital Discharge

- 1-3 ONS per day alongside regular oral intake (e.g. 2 ONS per day between meals),^{29,45,46,57} with adjustments based on patient needs and product composition.
 Prescribe 1 'starter pack', evaluate tolerance and acceptability to guide the ONS prescription ensuring flavour preferences are met.
 Provide red leaflet: 'Nutrition Drinks (known as oral nutritional supplements) Advice for patients and carers'
 Consider ACBS (Advisory Committee for Borderline Substances) indications (see page 7)
 Communicate goals and expected outcomes across care settings.
 Review at least monthly.

Considerations (for further information see p6-8)

- **Advice on ONS** should always be accompanied and underpinned by dietary advice (and dietary counselling where available) to maximise intake from food and drink
- **Nutrition Counselling & Motivation:** Ensure patients understand the role of ONS in their treatment and engage in discussions to support adherence
- **Condition-Specific Selection:** Choose ONS based on individual needs (e.g. high protein for frailty/hip fractures, low volume for reduced appetite, etc.)
 - **New Prescriptions & Preferences:** Unless otherwise specified, prescribe a range of flavours and encourage individuals to discuss preferences with a pharmacist to support adherence. Consider texture, flavour, and patient preference - a starter pack can help identify preferred flavours. If a hospital-preferred product isn't on the formulary consider discussing further with a dietitian, as a specific supplement may need to be prescribed to meet the individual's nutritional needs
- **Sustainability & Wastage:** Incorrectly prescribed products may lead to wastage - aligning selection with patient needs can improve adherence and reduce environmental impact

At 4 weeks

Monitor Progress:

- Check adherence with ONS prescription; amend type/flavour if necessary to maximise nutritional intake
 Review goals set and adjust accordingly
 Consider weight change, strength, physical appearance, appetite, ability to perform activities of daily living
 Monitor monthly or sooner if clinical concern

Goals met/Good progress:

- Encourage oral intake and reinforce dietary advice
 Consider reducing to 1 ONS per day for 2 weeks before stopping
 Maximise nutritional intake, consider self purchased nutritional supplements, if suitable (see advice on pages 6 and 7)
 Monitor progress, consider treating as 'medium risk' (see page 8)

Goals not met/Limited progress

- Evaluate adherence to ONS and dietary advice; amend prescription as necessary, increase number of ONS per day or change ONS e.g. to one which is more nutrient dense or high in protein
 Reassess clinical condition, if no improvement, consider more intensive nutrition support or seek advice from a Dietitian or GP
 Consider goals of intervention, ONS may be provided to support individuals with deteriorating conditions

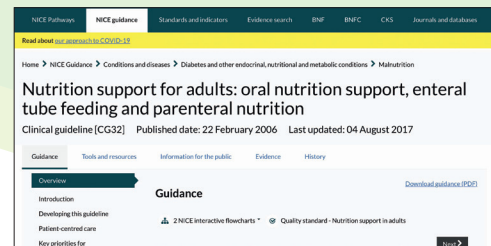
When to stop ONS prescription

- Goals of intervention have been met
 Individual is clinically stable/acute episode has abated
 Individual is back to their normal eating and drinking pattern²⁹ and is no longer at risk of malnutrition
 Nutritional intervention is no longer appropriate

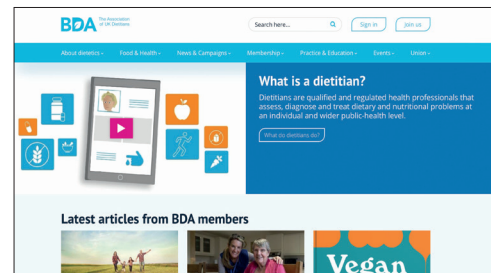
ONS – oral nutritional supplements/sip feeds/nutrition drinks as per British National Formulary (BNF) section 9.4.2⁵²
 Advice on ONS prescription according to consensus clinical opinion.

ONS prescription-units to prescribe per day e.g. 2 ONS = 2 bottles/units of ONS per day
 * Some individuals may require more than 3 ONS per day – seek dietetic advice

Useful information



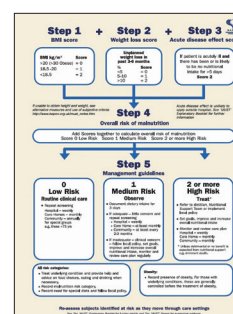
NICE
National Institute for Health and Care Excellence [nice.org.uk](https://www.nice.org.uk)
NICE CG32: Nutrition Support for Adults
NICE QS24: Nutrition Support in Adults
NICE Clinical Knowledge Summary - Adult Malnutrition



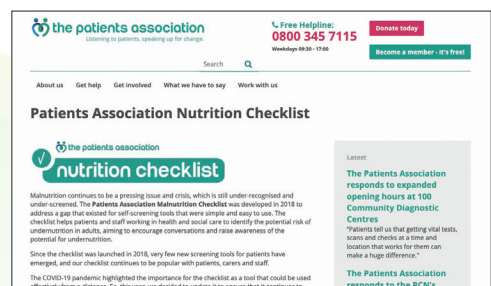
BDA
British Dietetic Association.
Fact sheets and key documents - [bda.uk.com](https://www.bda.uk.com)



Medscape
Guidelines for managing adult malnutrition in the community.
<https://reference.medscape.com/cc2/p10/managing-adult-malnutrition-community-2022a1001jh6>



BAPEN
British Association for Parenteral and Enteral Nutrition. Key documents and reports, 'MUST' toolkit, including 'MUST', explanatory booklet, e-learning and 'MUST' calculator - [bapen.org.uk](https://www.bapen.org.uk)



The Patients Association Nutrition Checklist
Offers a practical alternative when validated screening tools can't be used (e.g. due to lack of training or measurements). It helps identify those at risk of malnutrition and signposts to appropriate support:
patients-association.org.uk/patients-association-nutrition-checklist-toolkit

Malnutrition Pathway Resources

The Malnutrition Pathway website - malnutritionpathway.co.uk - provides a comprehensive collection of free evidence-based materials to support the identification and management of malnutrition in the community. These resources include guidelines, fact sheets, patient materials, videos, and podcasts, designed to assist healthcare professionals, patients, and carers in understanding and addressing malnutrition effectively.



Patient & Carer Resources

A range of resources are available to support individuals and their families, including practical guidance on nutritional support and managing daily dietary needs. Additional materials focus on adding protein into daily diets and provide advice on managing symptoms and issues that may interfere with the enjoyment of food.

malnutritionpathway.co.uk/leaflets-patients-and-carers

Care Home Resources

Specialist materials to support care home staff in recognising and addressing malnutrition, ensuring residents receive appropriate nutritional care.

malnutritionpathway.co.uk/carehomes

Disease-Specific Conditions

Guidance and tools focused on malnutrition management within specific health conditions, providing targeted support for healthcare professionals in integrating nutritional care into broader disease management strategies.

malnutritionpathway.co.uk/specific-resources

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This document represents the wealth of data that is available in the area of malnutrition and oral nutrition support. It incorporates the most up to date clinical data. Inclusion of a number of older studies or reports are included as they remain highly relevant and have not been superseded.

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Consensus Panel

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This document was reviewed by **Dr Graham Stretch**, President of the PCPA, Partner at The Argyle GP Surgery, and Lead Pharmacist (Care Homes) Ealing Community Partners.

Panel members on the 2012, 2017 and 2021 editions of the document

NB: Previous panel members included some of the current consensus panel as well as Dr Ailsa Brotherton; Senior Research Fellow, Pamela Mason; Community Pharmacy and Nutrition Consultant, Dr Rachel Pryke; Royal College of General Practitioners Clinical Champion for Nutrition for Health, Iain McGregor; Clinical Director Healthcare Education and Registered Nurse, Barbara Parsons; Community Pharmacist and Head of Pharmacy Services at the Pharmaceutical Services Negotiating Committee (PSNC), Carolyn Doyle, Royal College of Nursing and Dr Ann Ashworth, Consultant Dietitian.

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This document has been produced by a panel of healthcare professionals experienced in working with patients who are malnourished. The Malnutrition Pathway is a registered Community Interest Company (C.I.C) that operates as a not-for-profit, reinvesting all funding into initiatives that raise awareness of disease-related malnutrition and empower healthcare professionals, patients, and families to take timely action.

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Sustainability Commitment

The Malnutrition Pathway is actively working to reduce its carbon footprint by providing all materials on line and offering patient resources as free downloadable PDFs. Individual suppliers of ONS have their own environmental and sustainability commitments, including initiatives related to packaging, transportation, and sustainably sourced ingredients, which can be found on their respective websites.



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