MALNUTRITION & FRAILITY WORKSHOP

Perspective of Primary Care/ FCP Dietitians

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INTRODUCTION

Malnutrition can be caused by social factors, and disease-related factors

Challenge is to manage the patient in primary care due to the multimodal treatments and the effects of the disease and associated treatments.

Need to be understand the economic and environmental factors

(e.g. poverty, mobility, access to shopping, cooking)

3 million people in the UK are malnourished and 93% live in the community.

35% of people recently admitted to care homes

11% of people at GP practices

(stats malnutrition pathway)

COST IMPLICATIONS

More hospital admissions/readmissions and longer stay

Greater healthcare needs in the community (more GP visits, care at home, antibiotics)

STATISTICS

Snapshot from Central Norwich PCN (April 2024-August 2024)

Interventions: Nutrition Support Advice (Food First, Food fortification) or oral nutritional supplements

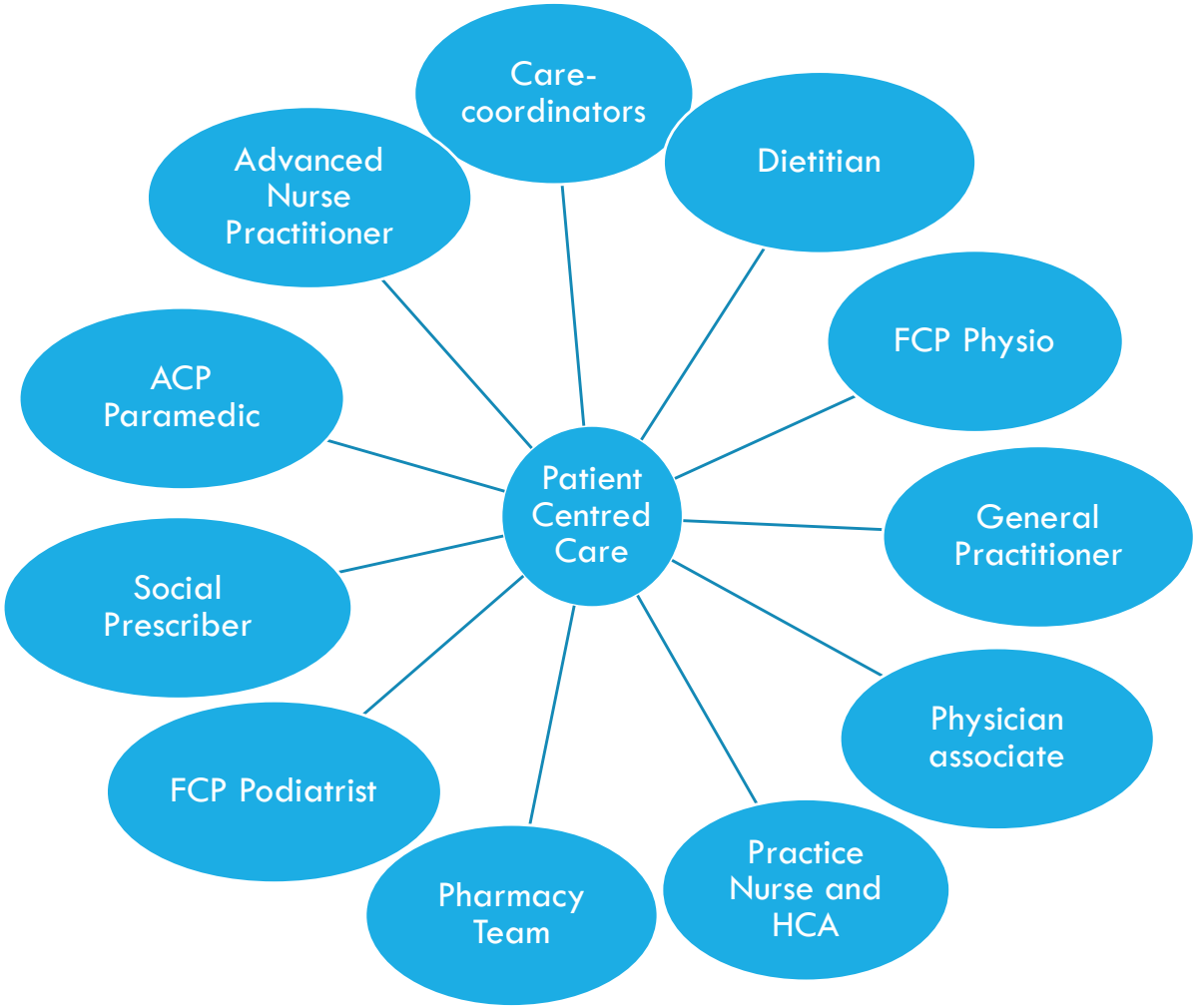
The higher amount of patient seen for unintentional weight loss is above 70 years old, these patients are at higher risk for frailty as well.

The high percentage of weight loss under 25 years is usually due to a form of disordered eating.

Patients seen by Primary Care Dietitian for Malnutrition/Frailty/Nutrition Support								
18-25 years	25-30 years	30-40 years	40-50 Years	50-60 years	60-70 years	70-80 years	80-90 years	>90 years
13	2	7	5	1	6	15	12	4

DIFFERENT ROLES IN PRIMARY CARE

Malnutrition Pathway Primary Care Networks Portal | Welcome



GENERAL PRACTITIONERS

Treat all common medical conditions and care for people with chronic illness and long-term conditions, aiming to keep them well and in their own homes. They are often the first port of call for individuals who are struggling with eating or weight.

Unintentional weight loss is a red flag for underlying pathology e.g. cancer and it is important that alongside referral for further investigation, that the unintentional weight loss which may result in malnutrition is also treated.

Play a central role in in Malnutrition:

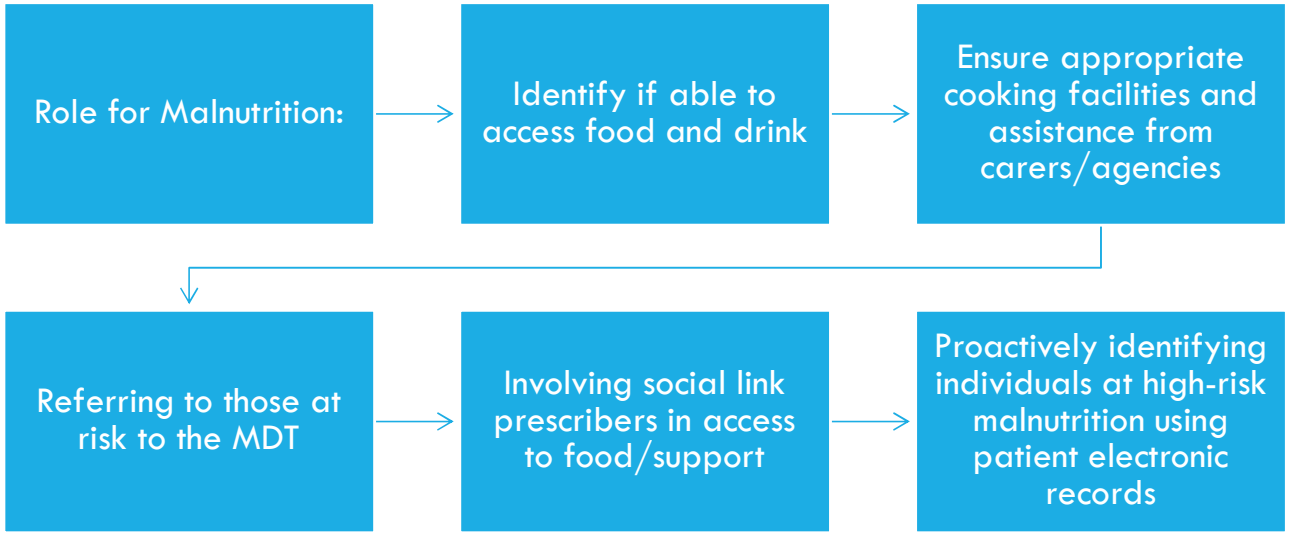
Identification

Assessment

Treatment

CARE CO-ORDINATORS

They proactively work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.



SOCIAL PRESCRIBERS

Social Prescribers provide personalised support to individuals, their families and carers to help them to take control of their health and wellbeing, live independently and improve their health access and outcomes.

Role in Malnutrition Treatment: Identification and onwards referrals

They are well placed to discuss how patients are managing with accessing and preparing food as well as identify potential challenges.

PHYSICIAN ASSOCIATES / ASSISTANTS

Physician Associates / Assistants provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems. They utilise history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable).

- They can play a pivotal role:
- identifying those at risk of malnutrition,
- carrying out screening and assessment,
- giving nutritional advice,
- referring on to an appropriate healthcare professional

PRIMARY CARE/ CLINICAL PHARMACISTS

Primary Care/Clinical Pharmacists take responsibility for medicines optimisation, reconciliation and providing expert advice on medicines. They undertake Structured Medicine Reviews (SMRs) with patients to proactively manage their inappropriate or complex polypharmacy needs.

Pharmacists are well placed to screen for malnutrition during SMRs:

can offer patients first line advice on their nutritional status,

monitor their progress,

provide ongoing support

and refer on to other members of the multi-disciplinary team such as a Dietitian as appropriate

PHARMACY TECHNICIANS

Pharmacy Technicians are responsible for supporting Clinical Pharmacists/PCN Pharmacists to implement effective medicine management, assist with medicine reviews, medicine reconciliation and medicine synchronisation, discharge management and managing the issuing of prescriptions.

Pharmacy Technicians can

monitor patients and identify those at potential risk of malnutrition,

offer them first line advice

refer them on to the Practice Pharmacist / Clinical Pharmacist or Dietitian for further support

Those who have been on an ONS for a long time and may need a review of their dietetic goal and to document if ONS is to continue, to change or to stop.

PRACTICE NURSES

Delivering care in general practice including screening and helping people to manage long term conditions.

identifying and managing patients with or at risk of malnutrition.

They can play an important role:

As they can often see patients repeatedly on a long-term basis, they are well placed for monitoring weight and the implementation of any nutrition care plans.

EXPERIENCE FROM PRIMARY CARE

STEPS TO MANAGING MALNUTRITION/ UNINTENTIONAL WEIGHT LOSS

Step 1: Identification of malnutrition: nutrition screening

Step2: Assessment: identifying the underlying cause of malnutrition

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

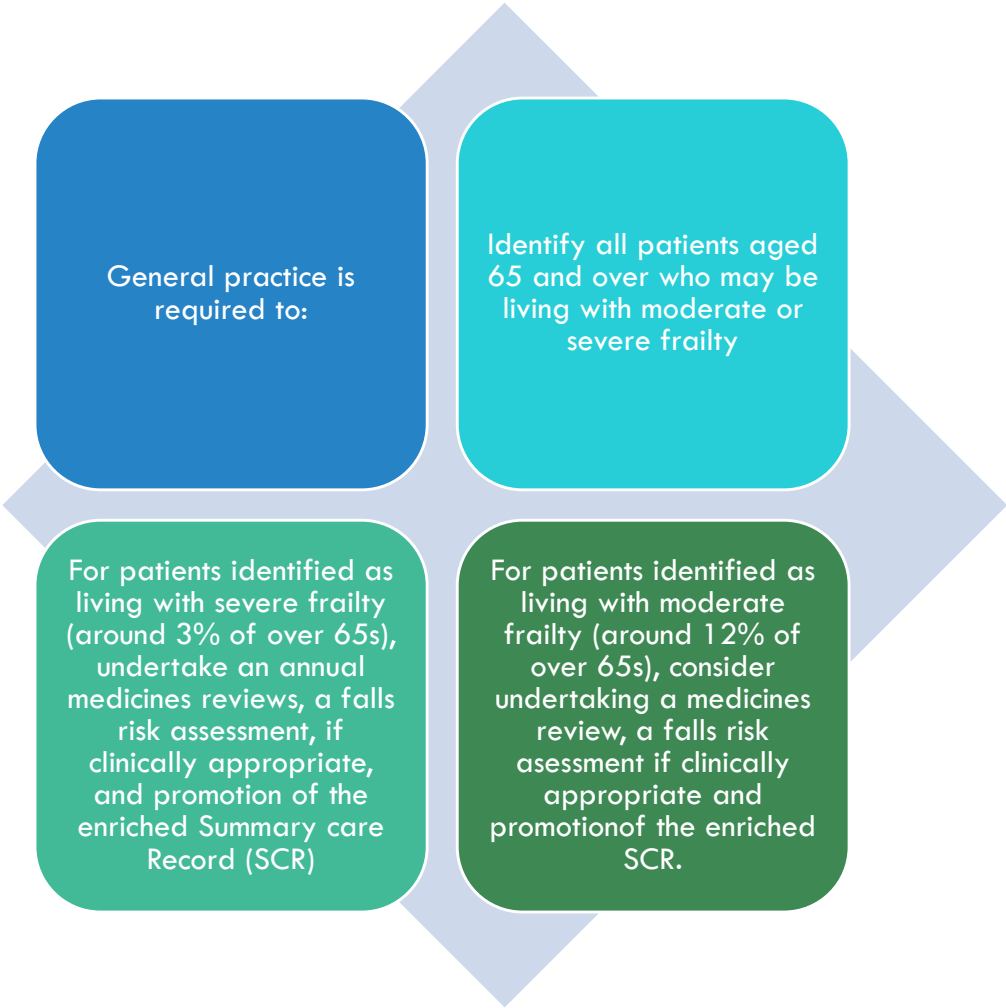
Step 4: Monitoring the intervention

ASSESSMENT – IDENTIFYING THE UNDERLYING CAUSE

Identifying the cause and symptoms, which are interefeing with the ability to eat and address them is important for the treatment plan

Non dietary and weight considerations:		
Vitals (BP, Temp, Sats, Pulse)	Frailty assessment (electronic frailty index, rockwood, timed up and go, PRISMA 7)	Dental assessment (dentures, ability to chew etc.)
Blood tests	Sarcopenia assessment (handgrip strength)	Mental Health- anxiety/depression (GAD/PHQ-9 score / 6CIT / GDS)
Falls risk assessment	Physical examination if clinically suitable (gastro, cardiac, respiratory)	Social assessment: Living alone Living in a residential home Access to cooking facilities
Frax score	Assessment of swallowing and refer to SALT if required	Samples (urine, FIT, thrush)

ELECTRONIC FRAILTY INDEX TOOL



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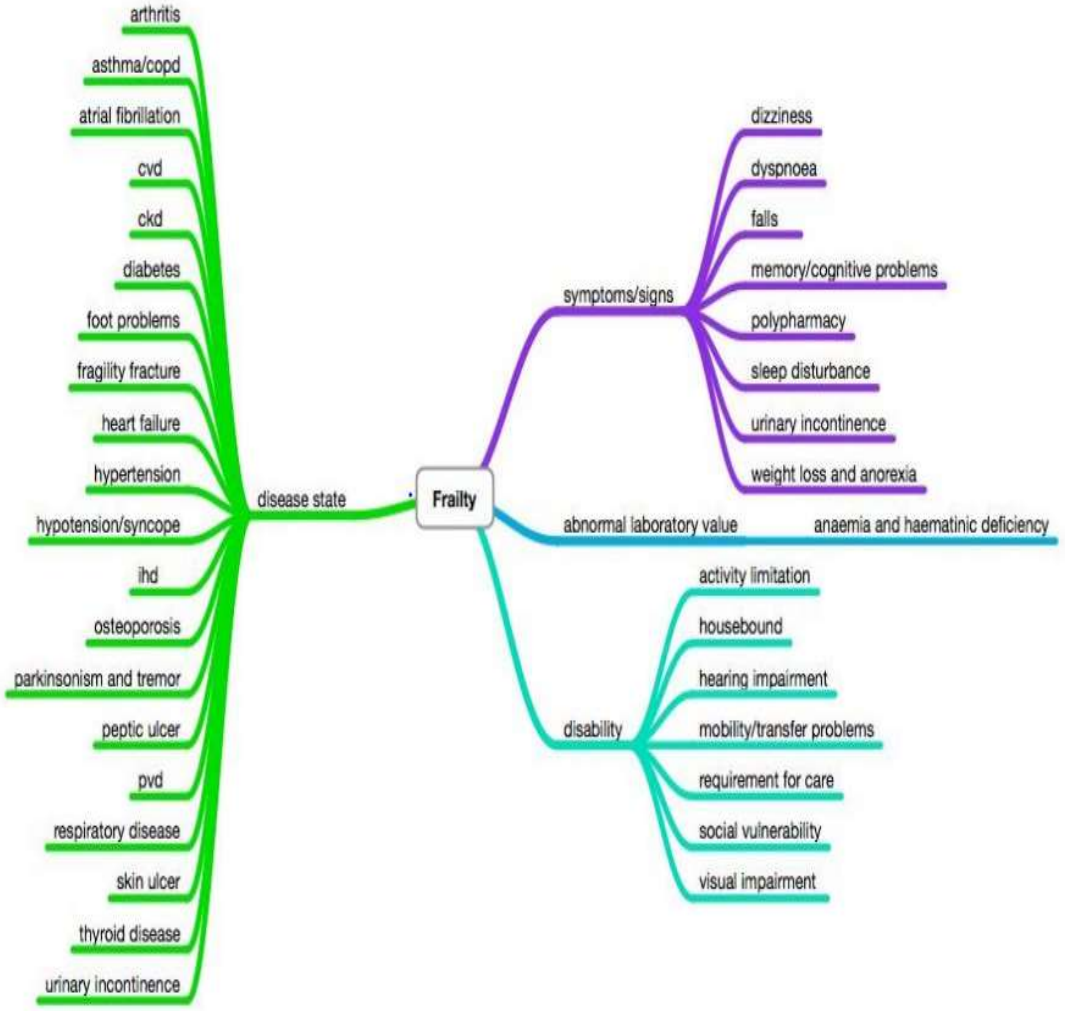

Figure 1 - Deficits included in e Frailty Index

Not a clinical diagnostic tool, it is a population risk strastifiction tool which identifies groups of people who are likely to be living with varying degress of frailyt but it is not able to do this for specific individuals

The FCP Dietitian can use this tool, by running a report on SystemOne to identify an individual who may be living with severe or moderate frailty, direct clincial assessment and judgement should be applied to confirm the diagnosis.

Aim is to support patients to live well for longer

FCP DIETITIAN WITH MALNUTRITION ON A DAILY BASIS

- MUST score and Anthropometry, MUAC
- Handgrips strength monitoring – screening for sacropenia
- BP, HR and temps
- Falls assessments
- Bloods: rule out vitamin deficiencies
- Food First, homemade milkshakes, fortification of meals
- Community Meals Services signposting
- Oral Nutritional Supplements
- Onward referral: OT, SALT, Physiotherapy, Social Prescribers

CARE HOMES ASSESSMENT

Experience from Charlene:

1. Link up with medicine optimisation team: PCN Clinical Pharmacist and the PCN Pharmacy Technicians
2. Trained pharmacists on MUST screening, to use during SMR
3. Attended weekly Care Home MDTS (GP, Nurse practitioner, pharmacist, Care Home Staff) - virtually
4. Food first, ONS if high MUST, review with Care Home initially two weeks, then three monthly (unless needs to be discussed in weekly MDT)
5. Sent care home the BDA Care Home Digest
6. Link up with community dietitians and ICB dietitians for training of care home staff on MUST, MUAC

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What we can offer as an FCP Dietitian?

- Enhanced Dietetic triage and assessment including dietary, physical, social and emotional well-being factors e.g. medications, physical activity, MECC, promoting screening opportunities, providing appropriate advice and signposting
- Basic observations: blood pressure, pulse, oxygen saturation levels and temperature
- Abdominal examination
- Blood test requests: FBC, haematinics, LFTs, renal, bone profile, refeeding profile, lipid profile, TFT, Hba1c, TTG, Ca125, amylase and inflammatory markers
- Sample requests: FIT, faecal calprotectin, faecal elastase, h pylori, urine samples and oral thrush swab / observations
- National tool completion: Q risk cardiovascular v3, FRAX score, falls, PHQ-4, GAD-7, 6CIT, GDS and Epworth sleep score
- *Advice* for GPs on local and national nutritional guidelines: Refeeding, Bariatric monitoring and supplementation
- Onward referrals for GP to approve: Gastroenterology, endoscopy, lower and upper GI 2ww (including indication in task)

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Positive reflections from Bexhill PCN supporting Frailty patients:

- Joint working to support our most vulnerable population – GPs, PPs, ACP Frailty Lead Paramedic, Frailty Care Coordinator, Dementia Care Coordinator, Diabetes Care Coordinator, Social Prescriber, Emotional Well-Being Service and Pharmacy.
- Team training for all staff doing home visits to complete basic observations – BP, pulse, sats, temperature.
- Onwards referrals to local services eg. Frailty Service (ACPs), Community rehab team (PT, OT, Pods), Adult social care.
- Sign posting eg. Befriending, Lifeline services, Counselling, Care for the Carers, Social groups, Exercise groups, Day centres, Care support, Meal provision, Benefit / debt support services.
- Discussions at monthly MDTs (GP lead, ASC, Community Nurses, PCN)
- Cost savings: £35,000 from annual ONS audit

Challenges:

- Variation across surgeries GP cover / triage / patient cover / workload
- Accessing ASC and different timeframe expectations
- Acute background to community working eased by being part of the team and able to discuss risk management and patient choice with capacity to make unwise decisions

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working towards a healthier community

Refeeding risk case study

int.sussex.ics.nhs.uk/clinical_documents/refeeding-syndrome-items-agreed-for-prescribing-to-prevent-or-manage-refeeding-syndrome/

- 77 year old male, been living in France for 10 years since retirement, returned to UK recently due to deterioration in health
- GP consult – weight loss, diarrhoea, poor appetite: FIT, calprotectin, bloods, 2ww referral, FCP Dietitian referral (urgent slot)
- Nurse consult same week as GP – B12 injection, noted BP low 85/50, discussed with GP amlodipine stopped – weekly monitor
- FCP Dietitian consult following week –
  - 54kg BMI 16, reports 12kg weight loss over 11 months (18% weight loss), intake <75% kcal requirement greater than 1 month - high refeeding risk.
  - Loose stool 2-3 / day past 18 months. No abdo pain, bloating, reflux, heartburn, burping, flatulence. Worsening lethargy, needing frequent rests.
  - History: type 2 DM, hypertension, b12 deficiency. In France reports had tried many antidiarrheals and ONS disliked, not effective not continued.
  - BP 79/58, pulse 89. Since GP consult: FIT positive, calprotectin raised. Colonoscopy abandoned too much pain. OGD in 2 weeks AW CT abdo date.
  - First bloods: Magnesium 0.52, Phosphate 0.7, Sodium 127, Haemoglobin 98 (others normal).
  - Taking metformin, statin and ferrous sulfate all brought back from France 3 month supply when moved.
  - Unaware of magnesium prescription from GP (Magnesium glycerophosphate 2 capsules TDS for 3 days).
  - 3 small meals estimate intake ~800kcal max. Fluids / day = 4 hot drinks tea / coffee semi skim milk, 1 water, 1 vodka tomato juice and 1 wine.
  - Reports fancies food, manages few mouthfuls, half portion max and feels full unable to manage more.
  - Attended clinic with wife who is supportive, wife does cooking encouraging with meals / snacks / fluids.
  - Plan – start magnesium script from GP, task GP re thiamine, forceval and latest BP, request repeat urgent refeeding bloods, encouraged with little and often intake, FFM, high calorie / protein snack list and finger foods list, ordered sample pack fortisip compact protein and fortijuice take od initially max and follow up call within 2 weeks.