

Malnutrition Information for Physicians

One third, and up to one half, of patients admitted to hospital are malnourished. Malnutrition at admission extends length of stay by ~3 days. (Allard et al, 2015, Allard et al., 2016; Curtis et al, 2016)

Malnutrition can be identified using nutrition screening tools at admission and diagnosed using the subjective global assessment (SGA) (Detsky, 1987). Screening can be completed by any health professional, while SGA requires training.

- SGA A: Well-nourished
- SGA B: Mild/moderate malnutrition
- SGA C: Severely malnourished

Top Tips

1. Be aware of nutritional status. Identify nutrition risk or conduct SGA as part of your assessment; alternatively ask the dietitian for the SGA score. Monitor the chart for nutritional information.
2. Malnutrition is treatable (there is evidence!); refer patient to a dietitian if the patient consumes $\leq 50\%$ of their meal tray in the past 3 days and/or significant weight loss occurs.
3. If a patient is malnourished, you can order a supplement (in some hospitals, you can order a small amount of supplement to be delivered with medications; typically called MedPass).
4. If conducting a patient visit during mealtimes, encourage the patient to eat.
5. If a patient is regularly eating $\leq 50\%$ of their meal, this will negatively impact their recovery; consider instituting supplemental enteral or parenteral nutrition.
6. Discuss nutrition (i.e. malnutrition status, low food intake, plans to support food intake and nutrition after discharge etc.) during rounds.
7. Record malnutrition as a complicating diagnosis that affected recovery and other health outcomes.
8. Manage pain appropriately so it is less of a barrier to food intake. Prescribe antiemetics and bowel management as required.
9. Avoid unnecessary use of NPO; if it is anticipated to be an extended status, consider parenteral nutrition.
10. Request accurate (not estimated) weights and encourage regular weight monitoring.

Key Evidence

Impact of malnutrition on length of stay

Allard, J.P., Keller, H.H., Teterina, A. Jeejeebhoy, K.N., Laporte, M., Duerksen, D. et al. Factors associated with nutritional decline in hospitalised medical and surgical patients admitted for 7 d or more: a prospective cohort study. *BJN*. 2015, 114(10), 1612-1622. [More](#)

Allard JP, Keller H, Jeejeebhoy KN, Laporte M, Duerksen D, Gramlich L, Payette H, Bernier P, Vesnaver E, Davidson B, Terterina A, Lou W. Malnutrition at hospital admission: contributors and impact on length of stay. A prospective cohort study from the Canadian Malnutrition Task Force. *J Parenter Enteral Nutrition*. 2016;40(4):487-97. [More](#)

Cost of malnutrition

Curtis L, Bernier P, Jeejeebhoy KN, Allard JP, Duerksen D, Gramlich L, Laporte M, Keller H. Costs of hospital malnutrition, *Clinical Nutrition*. 2016. doi.org/10.1016/j.clnu.2016.09.009. [More](#)

Barriers to food intake

Keller H, Allard J, Vesnaver M, Laporte M, Gramlich L, Bernier P, et al. Barriers to food intake in acute care hospitals: A report of the Canadian Malnutrition Task Force. *J Hum Nutr Diet*. 2015;28(6):546-557. [More](#)

Benefits of oral nutritional supplements

Milne, A.C., Potter, J., Vivanti, A., Avenell, A. 2009. Protein and energy supplementation in elderly people at risk from malnutrition (review). *Cochrane Database Syst. Rev.*, Issue 2. [More](#)

Assessing malnutrition

Detsky AS, Baker JP, Johnston N, Whittaker S, Mendelson RA, Jeejeebhoy KN. What is subjective global assessment of nutritional status? *J Parenter Enteral Nutr*. 1987;11(1):8-13. [More](#)

Integrated Nutrition Pathway for Acute Care (INPAC)

Keller H, McCullough J, Davidson B, Vesnaver E, Laporte M, Gramlich L, Allard J, Bernier P, Duerksen D, Jeejeebhoy K. The Integrated Nutrition Pathway for Acute Care (INPAC): building consensus with a modified Delphi. *Nutr J*. 2015;14:63. [More](#)