

Fighting the Skeleton in our Hospital Closet -

The Role of the Clinical Dietician:

Optimal nutrition is an integral part of health. Yet poor nutrition is a frequently encountered problem in our hospitals. Hospital malnutrition, already noted in 1974 as the “*skeleton in the hospital closet*”, continues to be a pervasive problem in our hospitals leading to increased morbidity and mortality, decreased function and quality of life, increased frequency and length of hospital stay, and higher health care costs. Providing individualised nutritional care to malnourished patients, even during a short hospital stay, has been shown to reduce morbidity and mortality. Clinical dieticians are therefore tasked with and passionate about providing optimal nutritional care to patients.

In patients able to eat orally, merely changing the consistency of the diet (e.g. changing from a soft to a liquid diet) or adding protein- and energy-enriched food and oral supplements, may help to improve nutritional status. Some patients, however, are unable to eat food normally (e.g. patients in an intensive care unit). These patients need to be given the correct amount and type of nutrition (protein, carbohydrates, fats, vitamins and minerals) through a tube and/or intravenously.

Tube feeding, also known as enteral nutrition (EN), involves the administration of a specially prepared liquid formula directly into the stomach or bowel through a tube. This form of nutrition is only suitable for patients whose gut (stomach and intestines) is functioning properly. Different liquid formulas are available. The dietician will therefore choose the most appropriate enteral formula, depending on the patient’s specific nutritional needs. Initially the patient will receive all of his nutrition through the tube feed alone. As the patient recovers (e.g. awake and able to swallow safely) he/she may start taking feeds orally. EN will only be discontinued once the patient is eating enough.

Intravenous feeding, also known as parenteral nutrition (PN), involves feeding a patient directly into the bloodstream (intravenously) through a drip. This form of nutrition is reserved for patients whose digestive tract is not functioning properly. For example, if they

- Have severe problems with their intestinal tract (blockage in the stomach or bowel), or if these have been removed.
- Have a hole (fistula) in their esophagus, stomach or bowel.
- Have severe nutritional problems before or after surgery to the gut and cannot tolerate EN.



Printing proudly sponsored by

- Are not tolerating adequate EN and/or losing a lot of weight

The dietician will prescribe a PN solution based on the patient's specific nutritional needs which will then be made up in a sterile room by a pharmacist. The dietician will monitor the patient on a daily basis (e.g. to make sure that the patient's blood levels of sugar, sodium, potassium, etc. are normal). When it is time for EN to be reintroduced, the dietician will gradually reduce the PN regimen over a few days.

Once the patient is awake and able to swallow safely, he/she will be encouraged to eat small meals and drink nutrient-dense liquid supplements.

References:

1. Tangvik RJ, Tell GS, Eisman JA, et al. The nutritional strategy: four questions predict morbidity, mortality and health care costs. Clin Nutr 2013; 1 – 8.
2. White JV, Guenter P, Jensen G, et al. Consensus Statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition). JPEN 2012; 35 (3): 275-283
3. Malone A, Hamilton C. The Academy of Nutrition and Dietetics/The American Society for Parenteral and Enteral Nutrition Consensus Malnutrition Characteristics: Application in Practice. Nutr Clin Pract 2013; 28 (6): 639 – 650
4. http://www.criticalcarenutrition.com/index.php?option=com_content&view=article&id=166:feeding-your-family-member&catid=18:qi-tools-new&Itemid=19

