

Disease Related Malnutrition – Taking a National Approach to Action and Advocacy

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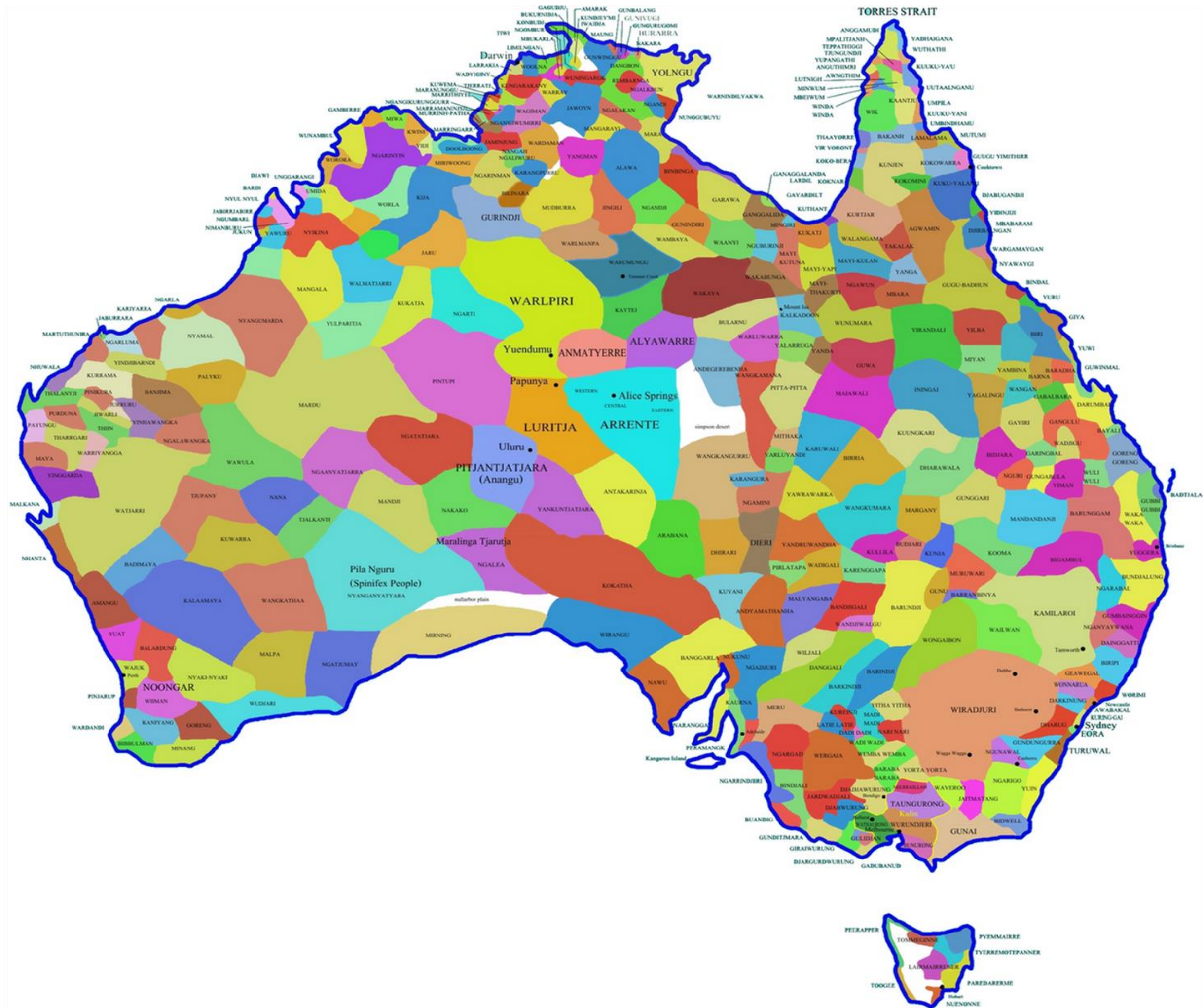


Disclosures

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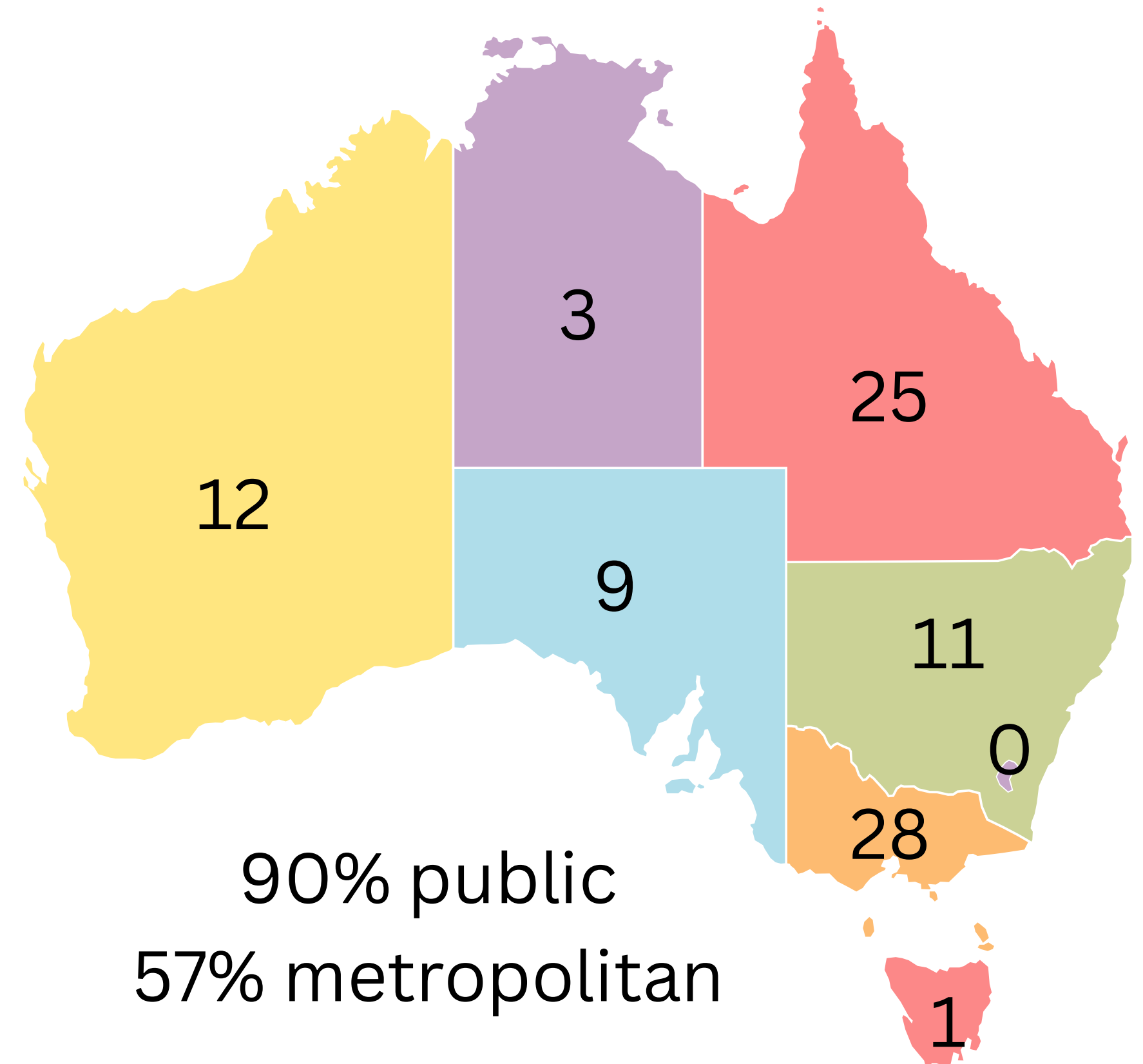
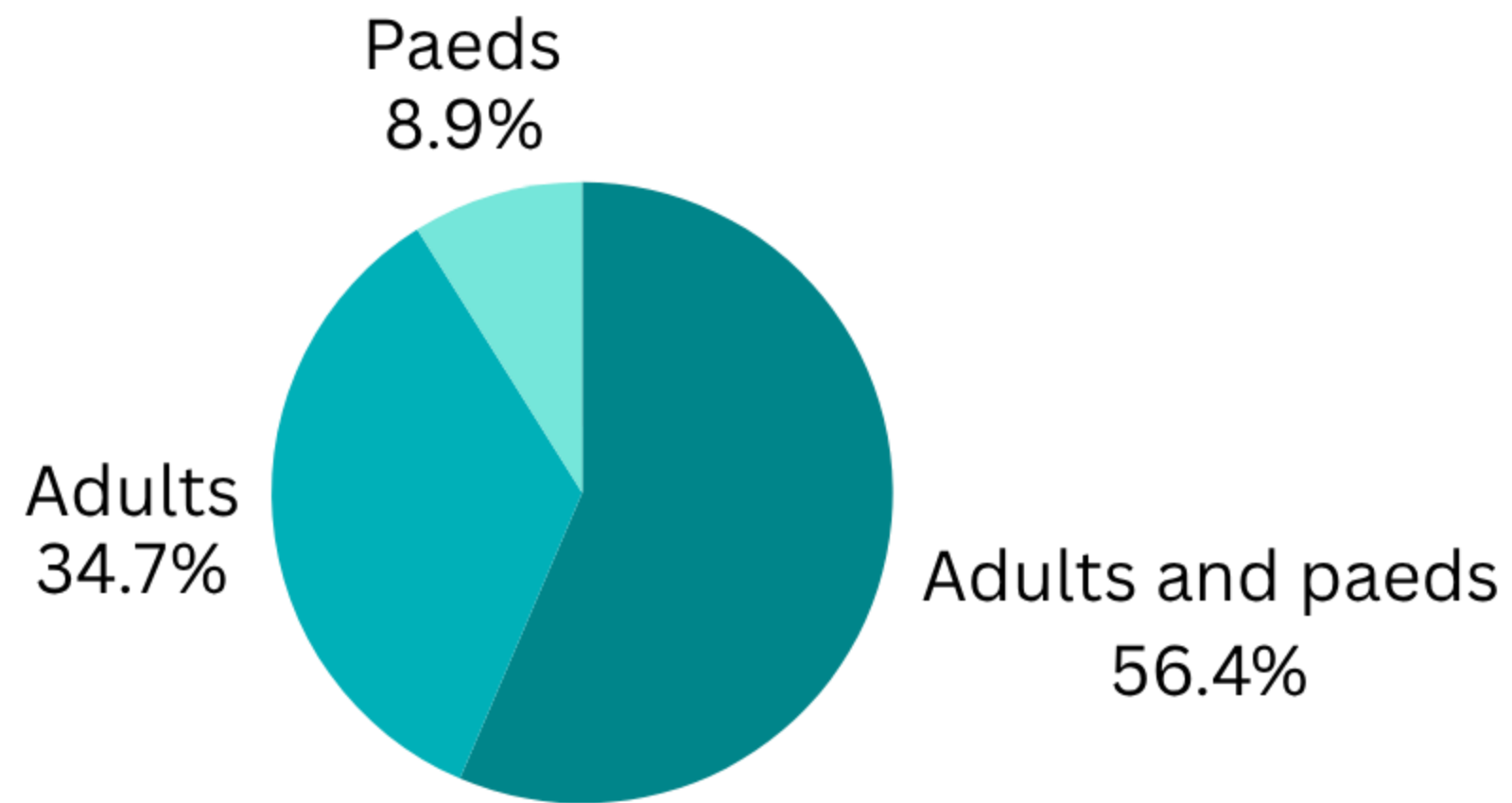
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I have no other conflicts of interest or commercial interests.



AuSPEN Hospital Malnutrition Survey 2025

n= 58 dietitian managers
from 89 hospitals



What have we achieved?

Let's go back to the mid-90s...

Only 9% of Australian hospitals had a nutrition screening policy in place

Where screening was in place, it was generally

- undertaken by dietitians
- for particular patient groups only
- took >10 minutes to screen each patient

No validated malnutrition screening tools

Confusion between malnutrition screening and assessment

No standard nutrition assessment tool

Malnutrition diagnostic criteria included BMI and albumin



Nutrition screening practices in Australian hospitals

Maree Ferguson and Sandra Capra

Australian Journal of Nutrition and Dietetics (1998) 55:4 157

1997

Malnutrition Screening Tool published
First Australian studies on the impact of malnutrition coding on case mix funding
Aged Care Quality Standards

Development of a Valid and Reliable Malnutrition Screening Tool for Adult Acute Hospital Patients

MAREE FERGUSON, PHD,*† SANDRA CAPRA, PHD,* JUDY BAUER, M HLTH SC,† AND MERRILYN BANKS, M HLTH SC‡

2007

First multi-centre Australian study on prevalence of malnutrition in hospitals and racf

Prevalence of malnutrition in adults in Queensland public hospitals and residential aged care facilities

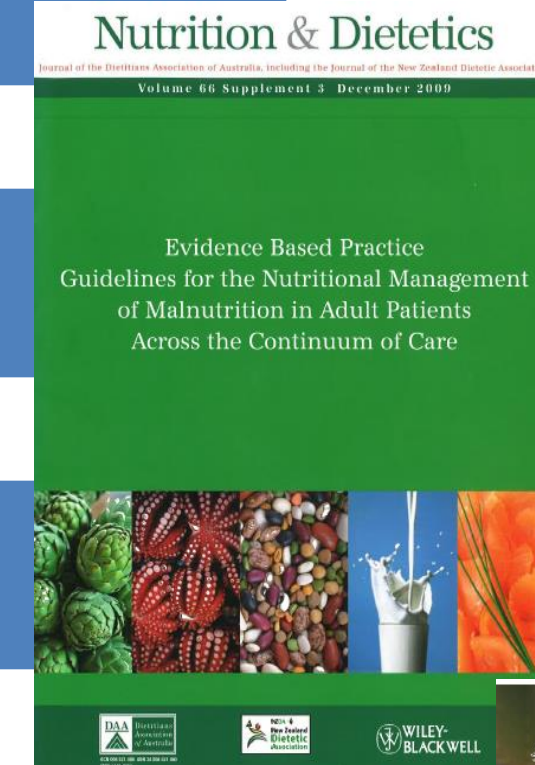
Merrilyn BANKS,^{1,2} Susan ASH,^{1,2} Judy BAUER^{3,4} and Deanne GASKILL³
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2008

Changes to malnutrition diagnostic criteria – dietitians able to diagnose malnutrition
• ICD-10AM codes included SGA criteria

2009

DA Evidence Based Guidelines on Malnutrition
National nutrition screening (MST) and assessment (SGA) roadshows



2012

ACHS introduced standard on Nutrition Care

2016

Australian Commission of Safety & Quality in Health introduced 'Nutrition Care' standards as part of the Minimizing Harm Standards in the Comprehensive Care Standards

2018

Hospital Acquired Complications – Malnutrition



How far have we come?

100% **Malnutrition screening in place**

100% **Using validated screening tools**
MST: 89%, PNST: 88%

98% **Screening by nurses**

100% **Validated nutrition assessment and/or criteria in use for adult* inpatients: SGA: 98%; GLIM: 56%**

*Paediatric data yet to be analysed

What needs to be addressed next?

Do we have appropriate governance in place?

Does your hospital have a malnutrition guideline or policy in place?

Yes – 70%

Does your hospital have a dedicated committee/group that allows you to report malnutrition data and concerns at the executive level?

Yes – 85%

- But of these, 28% said they are ineffective

Action 5.01 states

Clinicians use the safety and quality systems from the [Clinical Governance Standard](#) when:

- a. Implementing policies and procedures for comprehensive care
- b. Managing risks associated with comprehensive care

What are we doing about HAM?

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Selected best practices and suggestions for
improvement for clinicians and health system managers

Hospital-Acquired Complication **13**

MALNUTRITION

HOSPITAL-ACQUIRED COMPLICATION	RATE ^a
1 Pressure injury	10
2 Falls resulting in fracture or intracranial injury	4
3 Healthcare-associated infection	135
4 Surgical complications requiring unplanned return to theatre	20
5 Unplanned intensive care unit admission	na ^b
6 Respiratory complications	24
7 Venous thromboembolism	8
8 Renal failure	2
9 Gastrointestinal bleeding	14
10 Medication complications	30
11 Delirium	51
12 Persistent incontinence	8
13 Malnutrition	12
14 Cardiac complications	69
15 Third and fourth degree perineal laceration during delivery (per 10,000 vaginal births)	358
16 Neonatal birth trauma (per 10,000 births)	49

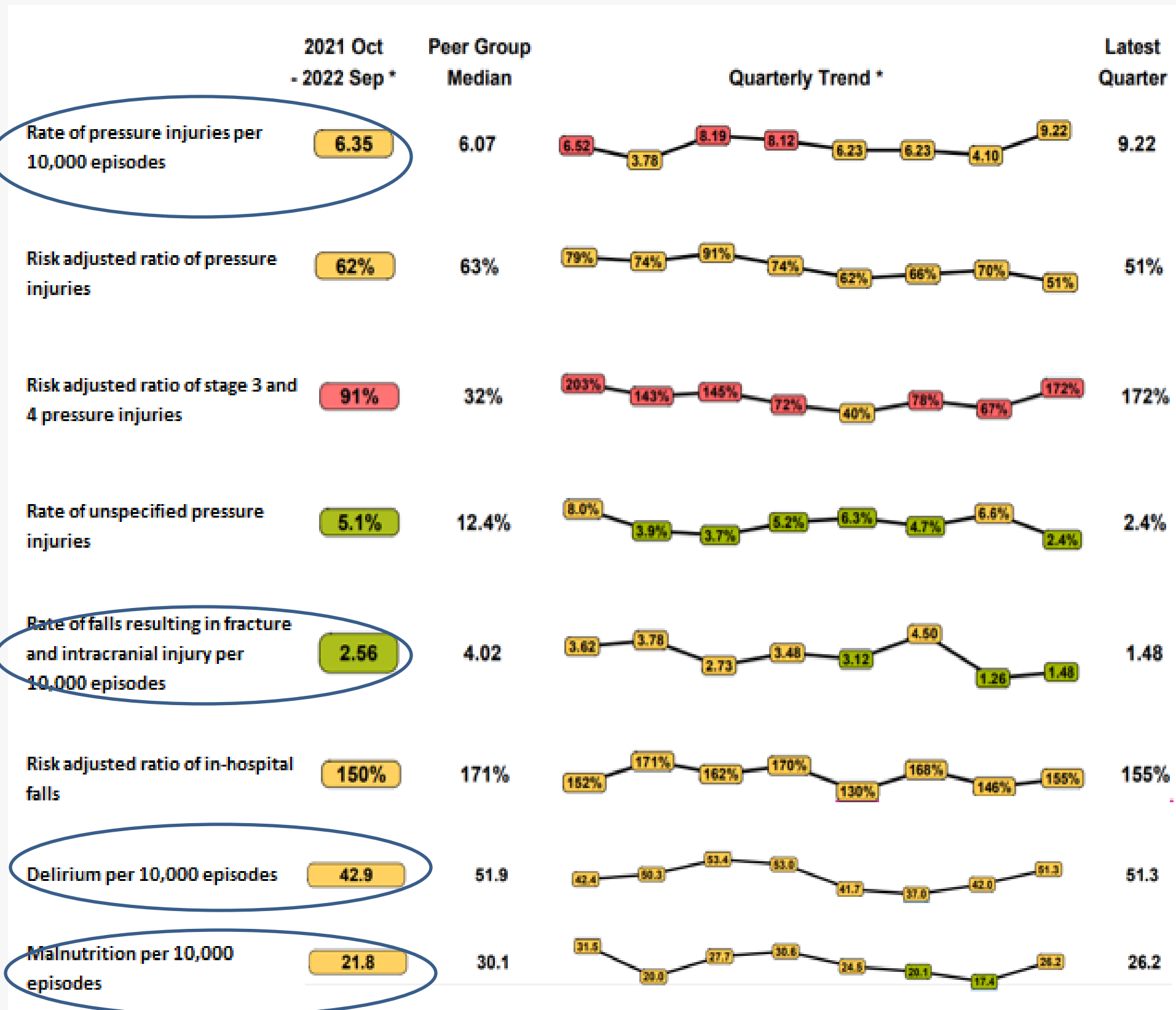
a per 10,000 hospitalisations except where indicated

b na = national data not available

1 in 4 long stay acute inpatients experience nutritional decline^{1,2}

- Higher incidence than falls, pressure injuries, VTE
- Complex etiology with patient and hospital-level factors³
- Often under-recognised

Health Roundtable - Australasian Benchmarked Data, Oct 2021 - Sept 2022



* Quartiles calculated within peer group.

Source: Australian National Standards Report Oct 2021 - Sept 2022, Health Roundtable. Published 22/12/2022.

Source: Hospital-Acquired Complications Report Oct 2021 - Sept 2022, Health Roundtable. Published 20/12/2022.

Local study found 37.4 cases per 10,000 episodes

What are we doing about HAM?

Does your hospital have a guideline about the frequency of re-assessment to detect nutritional decline/ HAM?

Yes – 44%

- Variation in frequency, weekly to monthly

What documentation is required for your medical coders to code a diagnosis of HAM?

Generally comprehensive understanding

- However, 16% were 'unsure'
- 29% have criteria for preventable vs non-preventable HAM

What are we doing about HAM?

When a case of HAM is identified and documented, what actions are taken at your hospital?

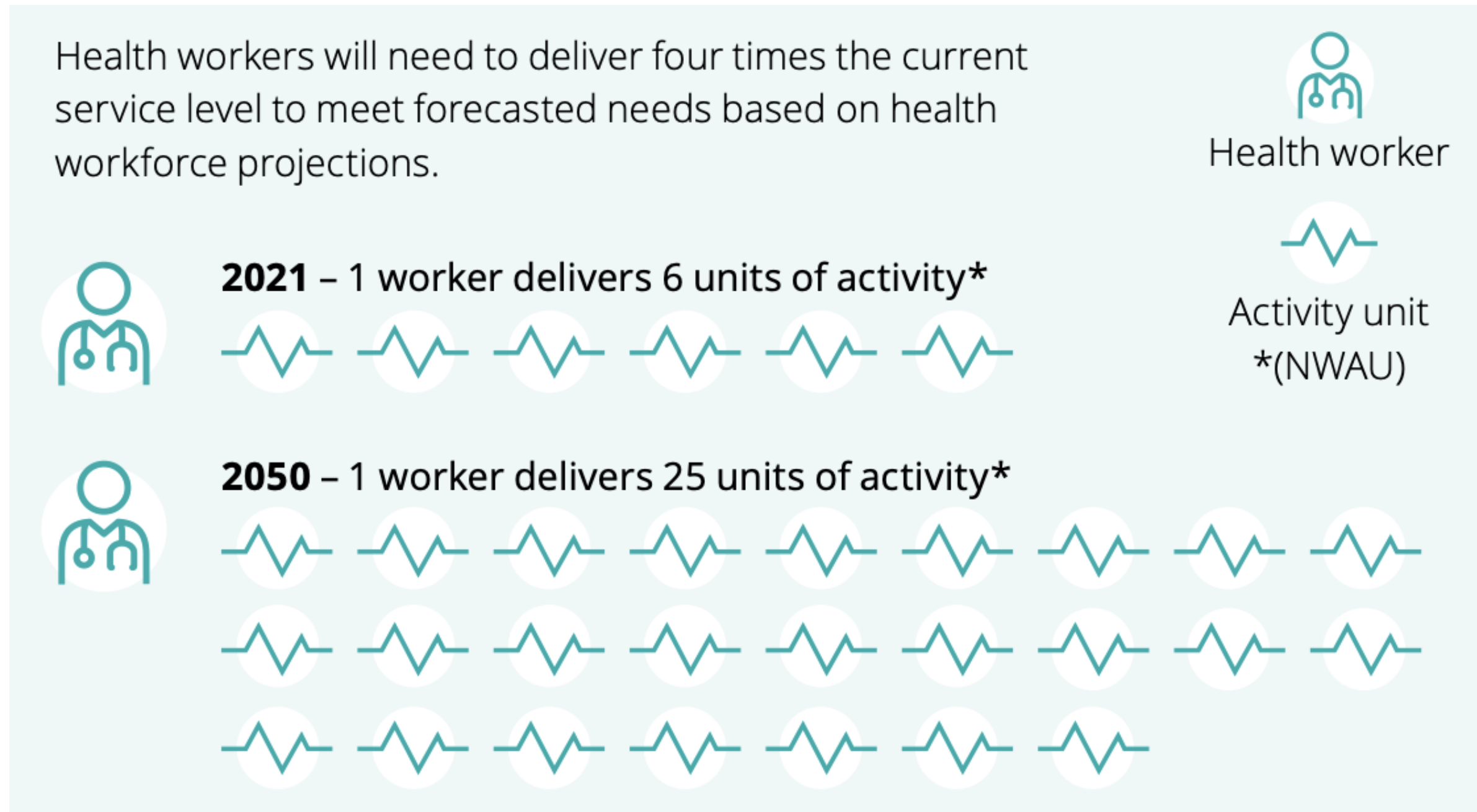
- 45% report in incident management system (e.g. RISKMAN)
- 43% report to nutrition-related committee
- 33% review the case in peer supervision/ team meetings
- 29% report no action is taken

Action 1.11 states

The health service organisation has organisation-wide incident management and investigation systems, and:

- a. Supports the workforce to recognise and report incidents
- b. Supports patients, carers and families to communicate concerns or incidents
- c. Involves the workforce and consumers in the review of incidents
- d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
- e. Uses the information from the analysis of incidents to improve safety and quality

Do we have a sustainable workforce model?



Deloitte (2022) *Australia's Health Reimagined* Report

Workforce to support systematised care:

- DAs/NAs: Median 0.5 FTE (range 0–10) – nil: 34%
- FS dietitians: Median 0.4 FTE (range 0.2–2.5) – nil: 31%

Who is delivering malnutrition interventions?

	HPHE menu
Routine/ blanket	35%
Shared with nurses or assistants	44%

Who is delivering malnutrition interventions?

	HPHE menu	HPHE snacks & drinks	HPHE education	ONS
Routine/ blanket	35%	23%		
Shared with nurses or assistants	44%	8%	20%	4%

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Shared with doctors				31%

Who is delivering malnutrition interventions?

	HPHE menu	HPHE snacks & drinks	HPHE education	ONS
Routine/ blanket	35%	23%		
Shared with nurses or assistants	44%	8%	20%	2%
Shared with doctors				31%
Dietitian only	19%	69%	77%	69%

Are we making a difference?

What are we measuring?

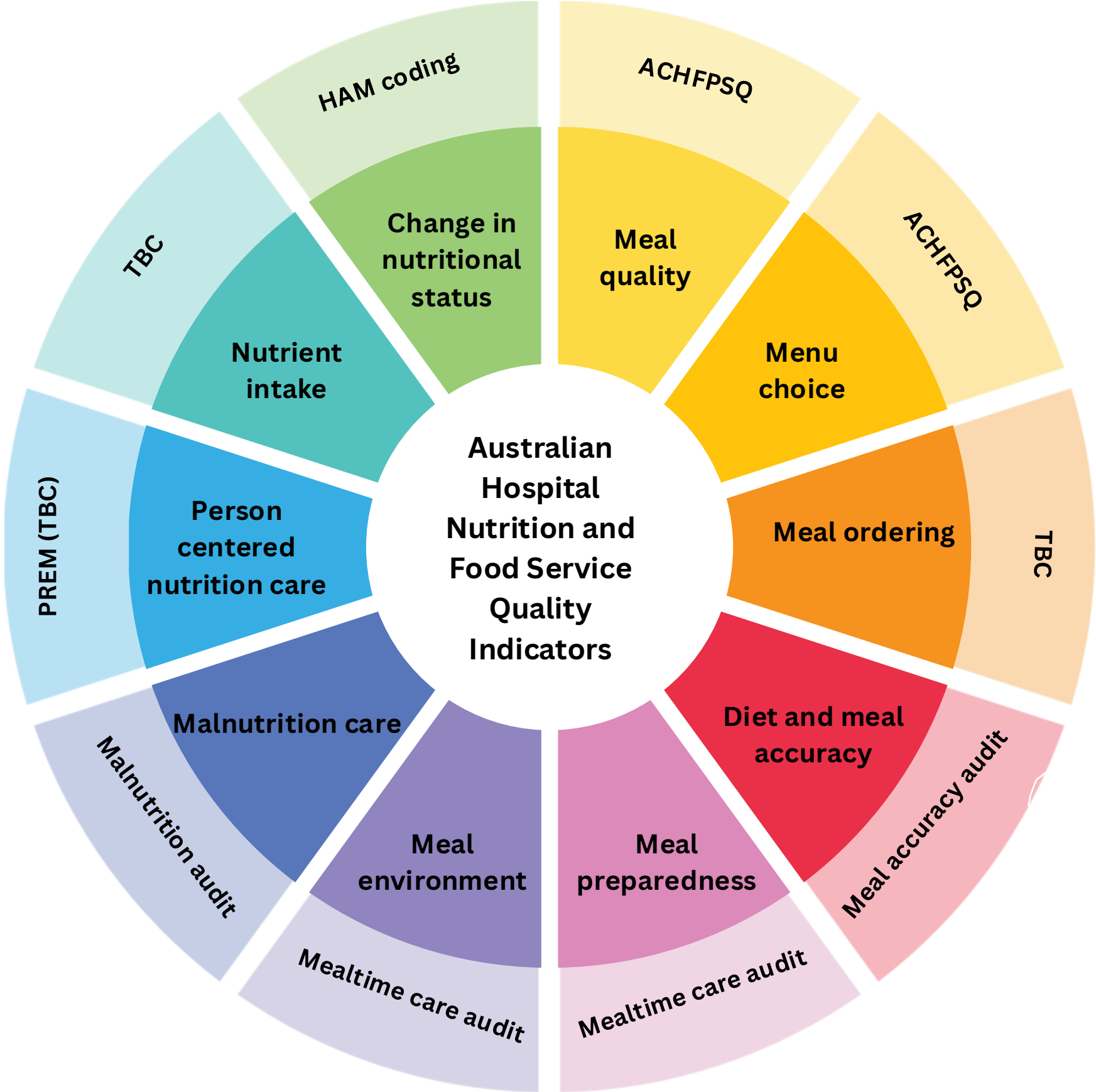
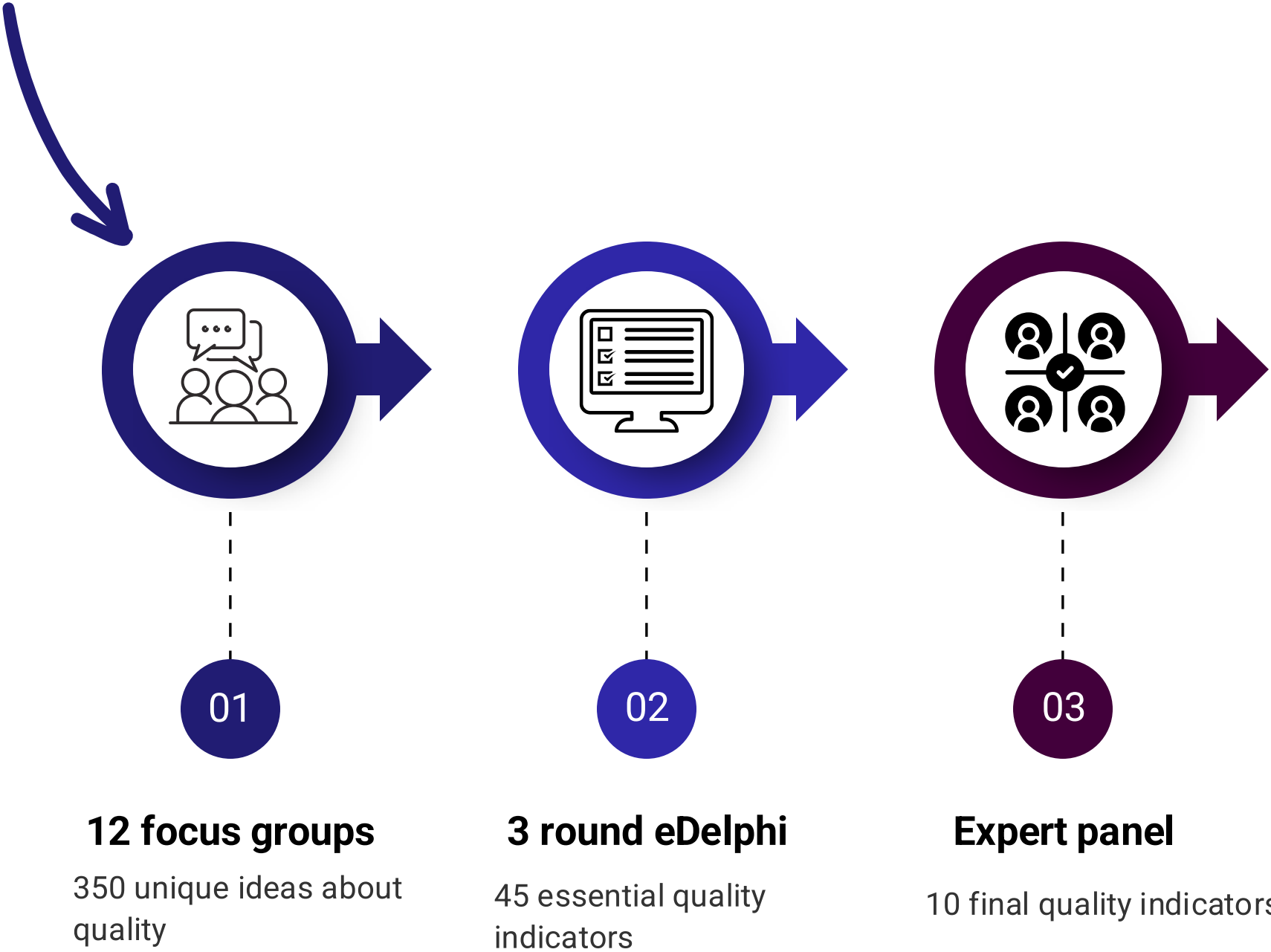
What data do you collect for purposes of quality improvement?

- 96%: malnutrition screening completion and/or accuracy
- 85%: malnutrition prevalence
- 96%: foodservice satisfaction

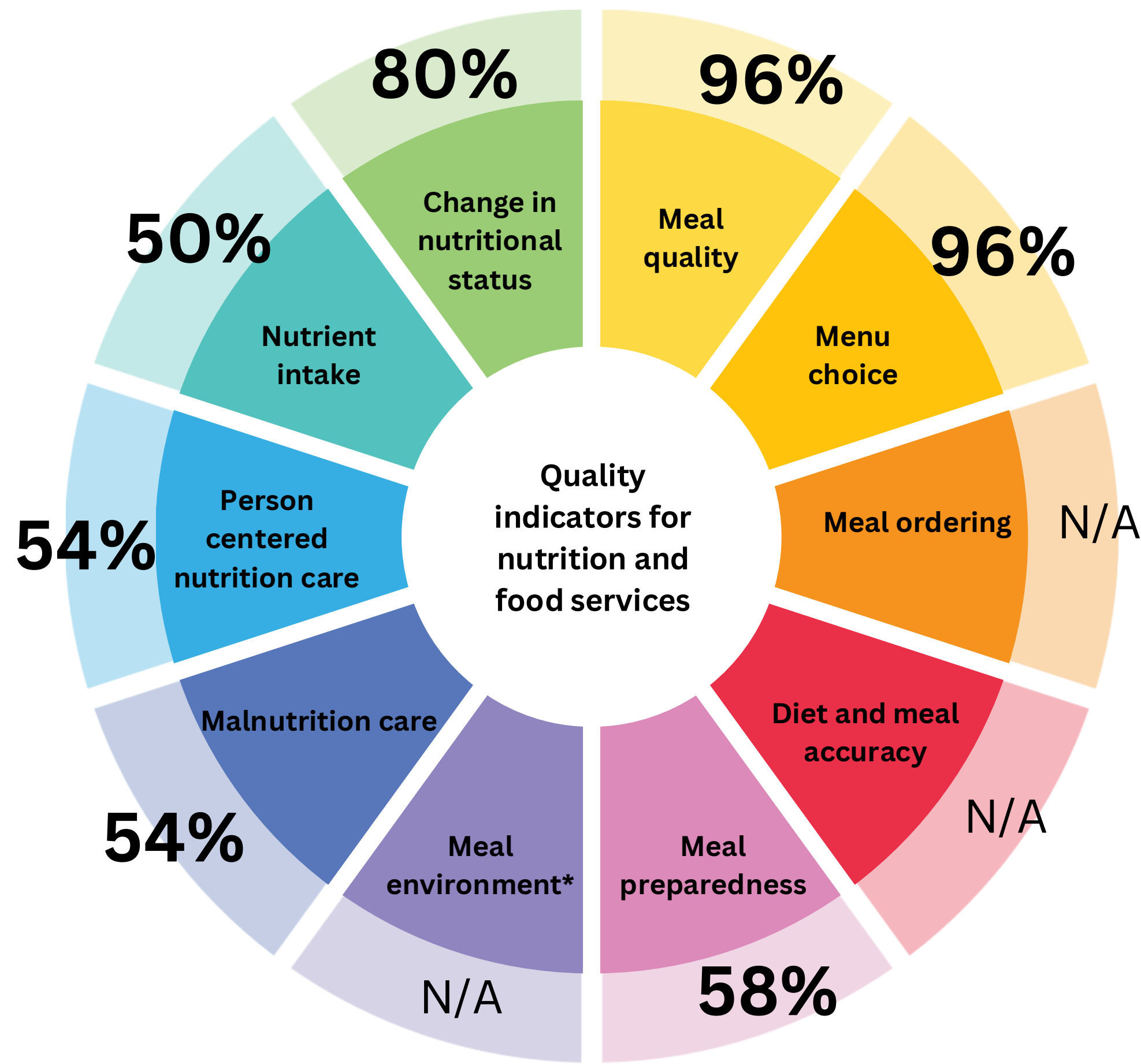
Are we measuring what really matters?

Measuring What Matters: Quality indicators for hospital nutrition & food services

51 multidisciplinary clinicians
88 dietitians
96 consumers
27 food service staff
+ existing guidelines/standards/literature



Are we measuring what matters?



N/A: not asked in survey

**What could we achieve
together?**

Creating Alliances Nationally to address Disease Related Malnutrition (CAN-DReaM)

The CAN DReAM is a commitment with the UN's Decade of Action on Nutrition 2016–2025 (extended to 2030)

Registered by the CNS-CMTF in 2022.

Aims to establish evidence-based practices and advocacy for policies to address Disease Related Malnutrition.



CAN-DReaM – AuSPEN’s Commitment – April 2024

1. Create a **national alliance** and set the foundation for a national coordination mechanism for improved DRM policy that will involve a diverse range of stakeholders.
2. Scope **existing national and state policies** that are relevant to DRM across settings and populations.
3. Design a **policy brief** on DRM and Policy Framework by 2025.
4. Expand and **strengthen global coordination** mechanisms for policies and practices to address DRM. This will enable other countries to create alliances to leverage best practices and policies from around the world, and to create capacity for policy level change globally.
5. Create **national and state health policy(ies)** to address DRM as prioritised in the policy brief by 2026.

A National Alliance: AuSPEN Malnutrition Taskforce

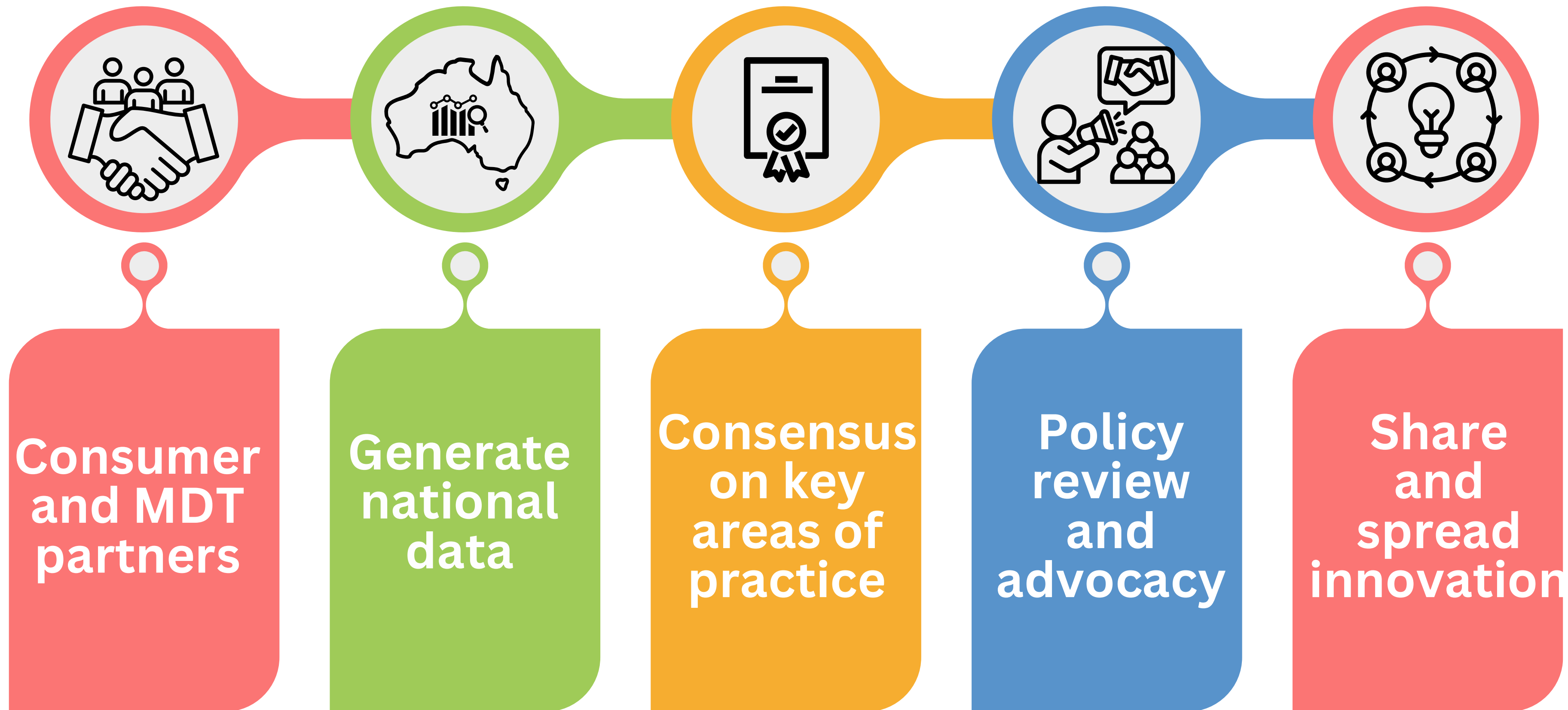
Goal is to drive improvements in management of disease related malnutrition across clinical settings

Build on existing efforts of AuSPEN

- Guidelines
- Annual scientific meetings
- Advanced nutrition courses
- LLL

Current members – dietitians from across 4 Australian states





Awareness

Advocacy

Impact

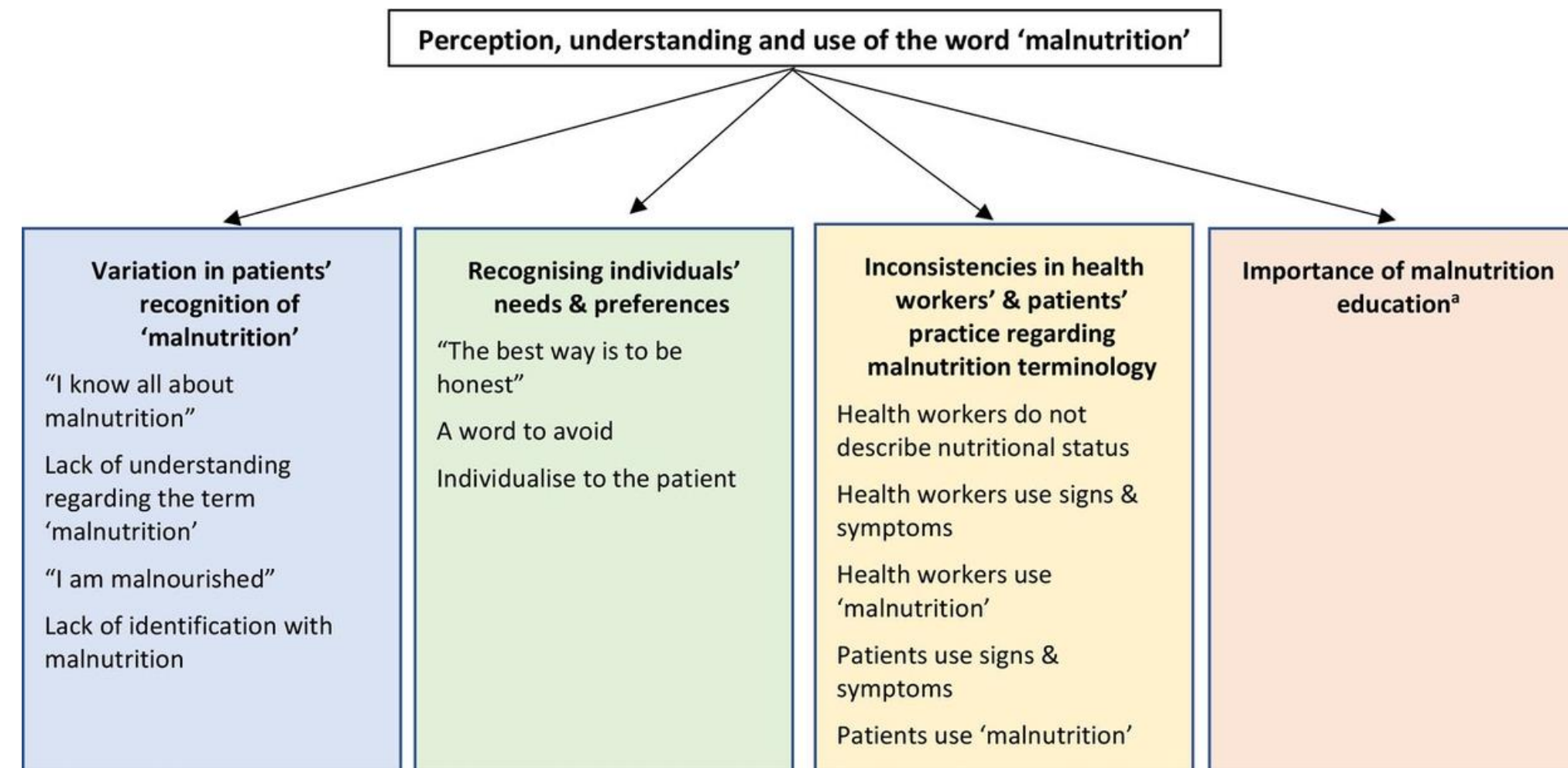


Consumer
and MDT
partners

Key for policy reform¹

Need shared understanding and ownership of malnutrition

- Differing views on the term 'malnutrition'^{2,3}
- Lack of knowledge and accountability within MDT⁴





**Generate
national
data**

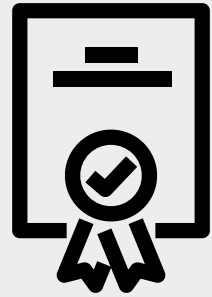
15 years since last national hospital malnutrition data!

Is there appetite for a national audit?

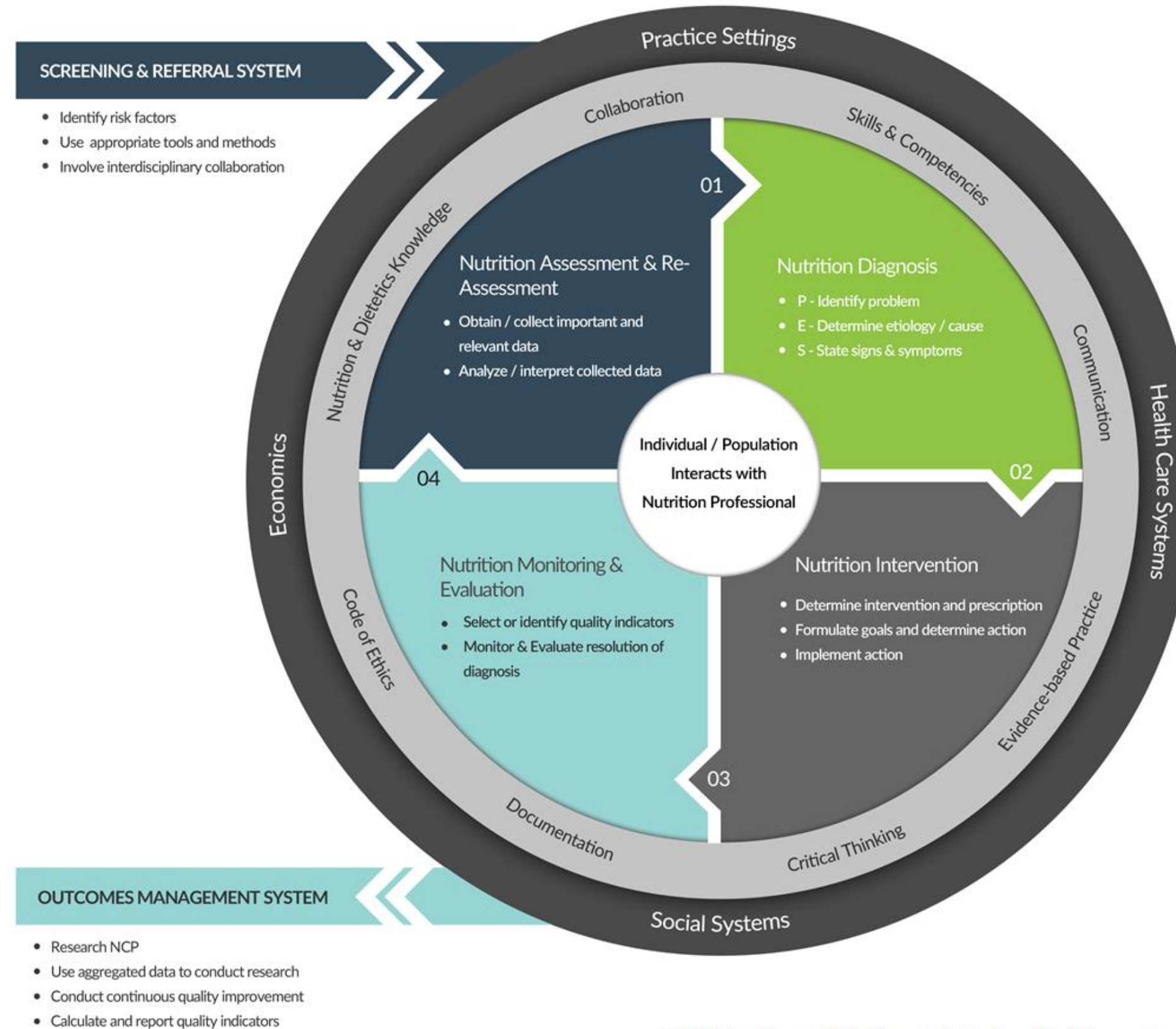
- 92% think it's very important to have recent data on malnutrition
- 62% are extremely likely to participate in national audit

Collectively there is more power to advocate for Dietitian and Assistant staffing and benchmarking if national approach taken.

Malnutrition prevalence is usually within the reported range but the practices around malnutrition management is the more important part to measure and report on to stimulate action.



Consensus on key areas of practice





Opportunities

- Policy review - Work undertaken in Canada^{1,2}
- Updates to NSQHS. 3rd ed.
- Changes to HAM classification and definition
- Workforce advocacy

Government Efforts

October 3, 2024

Malnutrition in Canada: Unveiling the Need for Priority and Policy Whitepaper

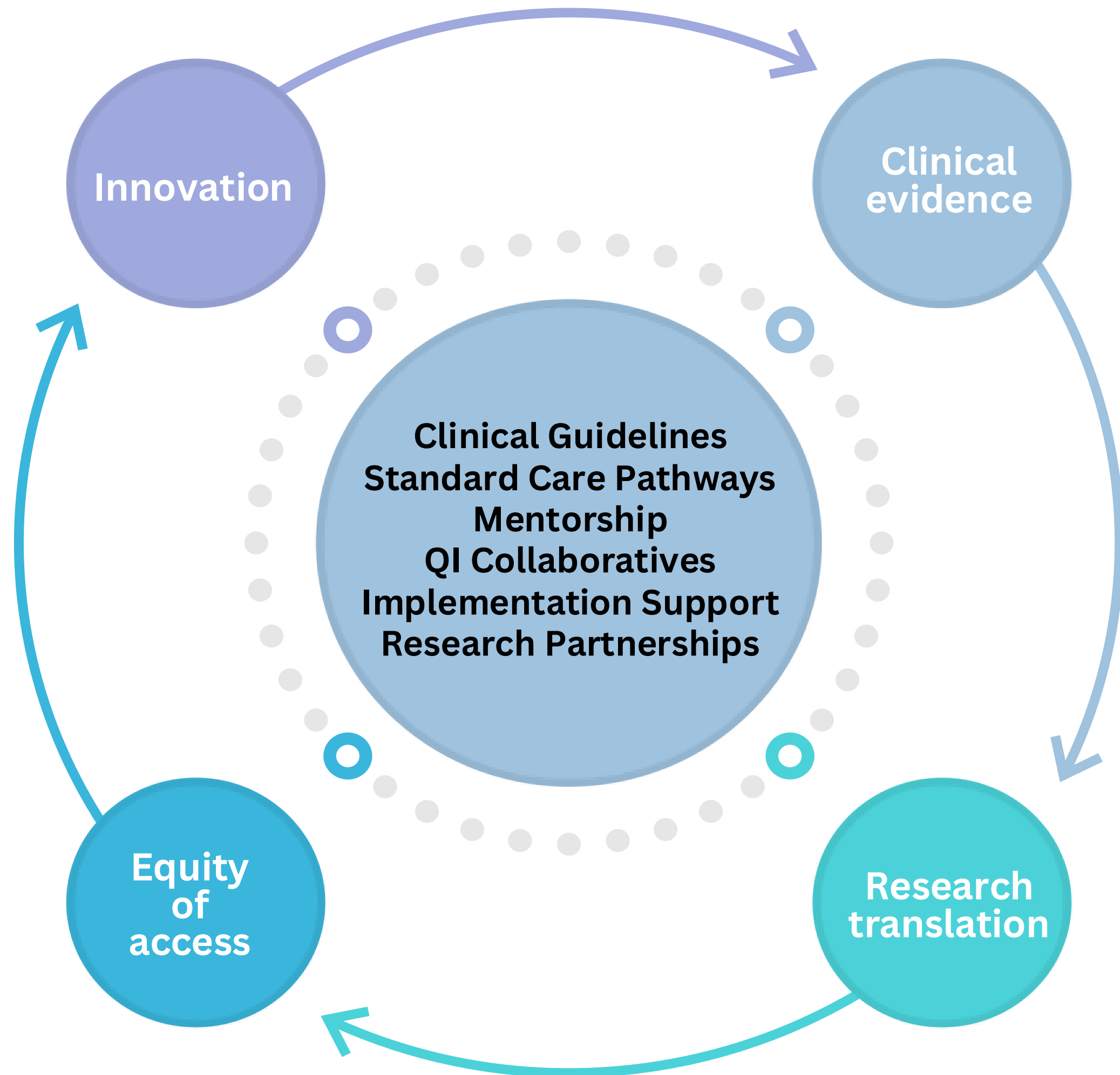


Malnutrition in Canada is a concern, and continues to go unrecognized, undetected and untreated. There is a pressing need to engage in dialogue to raise awareness and to advocate for change.

Malnutrition in Canada: Unveiling the Need for Priority and Policy is a Whitepaper created by CMTF/CNS to outline the prevalence, complexities and consequences of malnutrition, and importantly includes recommendations where governments can take action to benefit Canadians and health systems across Canada.

Over the coming months, leaders within CMTF/CNS will be meeting with government and healthcare officials and stakeholders to engage in important dialogue to facilitate needed action. We will continue to share our journey and opportunities where our broad network can participate. We are excited about this next phase and the opportunity to work towards positive changes.







**Consumer
and MDT
partners**



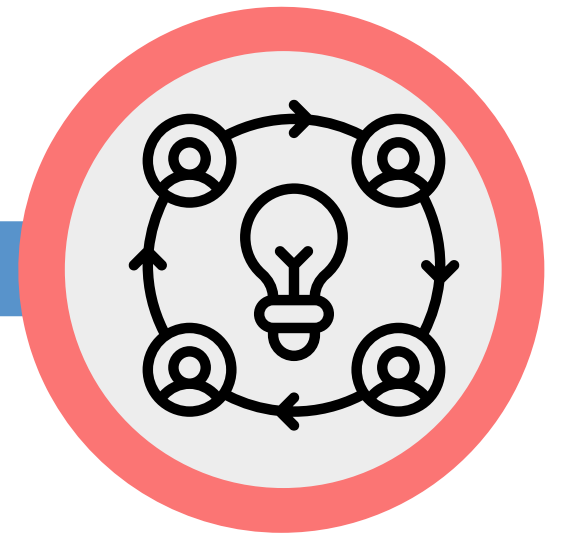
**Generate
national
data**



**Consensus
on key
areas of
practice**



**Policy
review
and
advocacy**



**Share
and
spread
innovation**

Thank You

AuSPEN Malnutrition Survey

Ibolya Nyulasi
Merrilyn Banks
Judy Bauer
Kia Noble
Bridget Agius
Kristie Bell

Thank you to all who completed the survey!



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