

AWMSG RECOMMENDATIONS REGARDING THE PRESCRIBING AND SUPPLY OF SIP FEEDS IN WALES: FOR ADOPTION AND WIDER DISSEMINATION

Background

In September 2004, the All Wales Medicines Strategy Group (AWMSG) identified concerns about the prescribing of sip feeds, and subsequently tasked the NHS Industry Forum (NHSIF) and the All Wales Prescribing Advisory Group (AWPAG) with considering and addressing the issues. The recommendations from NHSIF and AWPAG were combined ([9/AWMSG/0905](#)¹) and considered at the AWMSG meeting in September 2005. AWMSG advised that the All Wales Dietetic Advisory Committee (AWDAC) should be contacted regarding the development of the paper,² and preparation for the implementation of the National Institute for Health and Clinical Excellence (NICE) [guidance on nutrition support in adults](#).³

NICE guidance was issued in February 2006. The NICE guideline development group considered appropriate methods of feeding people who are still capable of deriving at least some of their nutritional requirements by conventional feeding, and/or have difficulty in swallowing, including the use of nutritional supplements and enteral and parenteral nutrition methods.³

Oral nutrition support is the provision of dietary advice to patients on how to increase overall nutritional intake, and the modification of food and fluid by:³

- fortifying food with protein, carbohydrate and/or fat, plus minerals and vitamins *and/or*
- the provision of snacks and/or oral nutritional supplements as extra nutrition to regular meals *and/or*
- changing meal patterns.

Sip feed is a term which is often used to describe oral nutritional supplements that are given to increase nutritional intake.³

This document describes key priorities for the prescribing and supply of sip feeds in Wales and is intended to complement NICE guidance. It should be used in conjunction with the NICE [quick reference guide](#) on nutrition support in adults.⁴ Sections of the [full guidance](#) have been discussed when they are relevant but are not mentioned in the quick reference guide. The recommendations made in this report focus on adult patients who have been identified as being malnourished, or at risk of malnutrition, and who are under consideration for oral nutrition support.

Nutrition support in adults: key priorities for implementation

This document should be read in conjunction with NICE Clinical Guideline 32: Nutrition support in adults — [quick reference guide](#).⁴ The rationale to support the key priorities is discussed later in this document.

Clinical priorities

When a person is recognised as malnourished, or at risk of malnutrition, following screening:

- the underlying cause of poor nutritional status should be clearly identified and appropriately managed.³
- treatment options include increasing menu choice and provision of snacks, support/supervision at mealtimes, food fortification, oral nutritional supplements, and vitamin and mineral supplements to meet dietary reference values.³
- since oral nutritional supplements presumably produce clinical benefits through increased nutrient intake, a similar increase in nutrient intake achieved by dietary means should lead to similar clinical benefits.³
- patients should be issued with a non-commercial patient information leaflet.¹
- patients should be issued with an individual treatment plan.¹

Prescribing priorities: hospitals¹

- Sip feeds on in-patient drug charts should be annotated with the intended duration of use.
- Patients should only be discharged with sip feeds following assessment by a dietitian who has recommended their use for a defined period post-discharge.
- The quantity supplied at discharge should be sufficient to enable effective continuity of care.
- When sip feeds are to be continued in primary care, dietitians should always provide a discharge letter which includes the indication, intended duration of use, arrangements for follow-up, and nutritional goals.
- General practitioners (GPs) should be informed about patients who do not attend dietetic follow-up so that alternative monitoring arrangements can be made.

Prescribing priorities: community¹

- Initial prescriptions can be written by stating the separate styles of sip feed (milkshake, yoghurt, juice or soup) and endorsing each with 'mixed flavours'. Alternatively, some products are available in starter packs.
- The total quantity should be for no more than two weeks initially.
- Clear directions for use should be specified on the prescription (e.g. take two daily between meals). 'As directed' should not be used.
- Sip feed prescriptions should be issued as monthly 'acute' prescriptions for the first three months. Monthly monitoring should take place during this period.
- Thereafter, patients stabilised on oral nutritional supplements should be reviewed at least every 3–6 months.
- Monitoring should be undertaken before a repeat prescription is requested and include an estimate of compliance (e.g. the volume of supplement consumed: $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$ of pack/carton), flavours and styles preferred, and normal dietary intake.
- Monitoring information should be shared with the prescriber when repeat prescriptions are requested.
- Sip feeds should only be prescribed to drug misusers if it is considered to be appropriate following assessment by a registered dietitian.

Care homes¹

- Dietetic support to care homes is needed.
- The use of pooled sip feeds is inappropriate and should not be permitted.
- Care homes should identify a member of staff to act as a nutrition link worker.
- All homes should have access to weighing scales, which are maintained and accurate.

Organisational priorities¹

- Direct supply of supplementary feeds to patients should be strongly discouraged.
- The pharmaceutical industry and nutrition companies should follow the Association of the British Pharmaceutical Industry (ABPI) [Code of Practice](#) for the provision of samples (clause 17).⁵
- Nurses, pharmacists, GPs and care home staff should be discouraged from accepting and using samples of sip feeds.
- A range of products is required in order to accommodate varying clinical need and patient preference.
- Training packages on nutrition and the appropriate use of sip feeds should be available across all local health boards (LHBs). Existing schemes should be assessed and accredited where appropriate by trust/LHB dietitians or AWDAC.
- A multi-disciplinary 'community nutrition team' approach is needed.

Factors contributing to disease-related malnutrition³

Problem	Cause
Impaired intake	<p>Poor appetite due to illness (a major and common cause), pain/nausea when eating, depression/anxiety, food aversion, medication, or drug addiction.</p> <p>Inability to eat because of diminished consciousness, confusion, weakness or arthritis in the arms or hands, dysphagia, vomiting, painful mouth conditions, poor oral hygiene or dentition, and restrictions imposed by surgery or investigations.</p> <p>Lack of food due to poverty, poor quality diet at home, in hospital or in care homes, or problems with shopping and cooking.</p>
Impaired digestion and/or absorption	Medical and surgical problems affecting the stomach, intestine, pancreas, or liver.
Altered requirements	Increased or changed metabolic demands related to illness, surgery organ dysfunction, or treatment.
Excess nutrient losses	<p>Gastrointestinal losses because of vomiting, diarrhoea, fistulae, stomas, or losses from a nasogastric tube or other drains.</p> <p>Other losses e.g. skin exudates from burns.</p>

Rationale for key priorities

Clinical priorities

Underlying cause

The underlying cause of poor nutritional status, both social and disease-related, should be clearly identified and appropriately managed. Disease-related malnutrition (as apposed to social malnutrition) is the Advisory Committee on Borderline Substances' (ACBS) indication for which sip feeds may be prescribed.⁶ Both factors need to be addressed as part of the treatment plan.

Food first

The Welsh Medicines Resource Centre (WeMeReC)^{7,8} and the Welsh Risk Pool (Standard 23: nutrition and catering)⁹ have stressed the importance of adequate daily menus and dietary manipulation, prior to the use of supplementary feeds.

This view is supported by NICE. The evidence base for oral nutritional supplements was assessed by the NICE guideline development group, who concluded that oral nutritional supplements may be more effective in increasing energy intake, and increasing weight, than dietary advice. However, they found that studies are too small to determine whether there are any differences in terms of mortality or clinical outcome, and there is little or no information on cost effectiveness. NICE also states that, since oral nutritional supplements presumably produce clinical benefits through increased nutrient intake, a similar increase in nutrient intake achieved by dietary means should lead to similar clinical benefits. They conclude that until further evidence is available, people with weight loss secondary to illness should either be managed by referral to a dietitian, or by staff using protocols drawn up by dietitians, with referral as necessary.³

Patient information

Patients have reported that they do not feel adequately informed about the rationale, directions of use, intended duration, or monitoring of sip feeds. Non-commercial patient information leaflets should be given to all patients who are discharged from hospital on sip feeds, or initiated on sip feeds in the community.

Prescribing priorities: hospital

The key priorities are concerned with improving communication issues between primary and secondary care, and ensuring continuity of care.

For in-patient initiation of sip feeds, the drug chart should be annotated with the intended duration of use. For example:

- discontinue on discharge.
- continue for/until (insert duration or nutritional goals).
- review in x weeks (insert duration).

Nutritional supplements should be written up on the drug chart by the dietitian and annotated RD (registered dietitian).

Hospital discharge

Patients who are discharged from hospital with sip feeds should have been assessed by a dietitian who has recommended that they should be used for a defined period post-discharge. The quantity supplied at discharge should be sufficient to enable effective continuity of care. Sip feeds should be treated as medications and, as such, dietitians should always provide a discharge letter when sip feeds are to be continued in primary care. The letter should include the indication for the sip feed, the intended duration of use, plans for follow-up, and nutritional goals (see **Appendix**). The GP will need this information before he can supply the next prescription for sip feeds.

To ensure continuity of care, GPs should be informed when patients do not attend follow-up with the trust dietetic department so that alternative arrangements can be made, where appropriate, for a suitably trained healthcare professional to monitor the patient.

Prescribing priorities: community

Initiation

Initiation of sip feeds by GPs is commonly influenced by communication from patients, relatives, district nurses, dietitians or care home staff. Dietitians can now prescribe via patient group directions if local agreements are developed. This requires specific training but no further qualifications.

A variety of flavours, textures and styles are required to suit different tastes and aid patient compliance. Initial prescriptions should include a range of products to enable the patient to find out which they prefer, and reduce waste. This can be achieved by prescribing a branded starter pack, or by writing a prescription for specified styles of sip feed (milkshake, yoghurt, juice or soup), utilising brand names, and endorsing each product with 'mixed flavours'. The total amount prescribed should be for no more than two weeks supply. Clear directions for use should be specified on the prescription. For example, 'take two daily between meals'. Some nutritional supplements are also available over the counter.

Acute and repeat prescribing

Once preferences have been established, sip feed prescriptions should be issued as 'acute' prescriptions for the first three months, with each script providing sufficient for 2–4 weeks. It has been suggested that the average duration of use of nutritional supplements is 45 days.

Following assessment at three months, it may be appropriate to put the sip feeds onto the repeat prescribing system. These mechanisms should reduce the risk of inappropriate continuation of supplements.

Monitoring

NICE states that healthcare professionals should review the indications, route, risks, benefits, and goals of nutrition support at regular intervals. They also provide a protocol for nutritional, anthropometric (measurement of the size and proportions of the human body) and clinical monitoring of nutrition support.⁴

Community nurses and care home staff also have a role in monitoring patients. Their records are kept within the care home or patient's home. Documentation and communication between staff who are undertaking monitoring and the prescriber should be improved.

Concordance

Information on consumption (not simply administration) of feeds is needed when a healthcare professional is considering whether or not the prescription should be continued. In hospitals and care homes consumption of supplementary feeds should routinely be recorded on an intake chart. Other community patients should also be monitored before a repeat prescription is requested. Monitoring should include an estimate of compliance (the volume of supplement consumed: $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$ of pack/carton), the flavours and styles which the patient prefers, and their normal dietary intake.

Pharmacist monitoring

As part of the new contract for community pharmacists there is provision for LHBs to develop and commission enhanced services. A service could potentially be developed for monitoring of patients who take sip feeds. Pharmacists are currently being invited by the industry to attend nutrition workshops. An enhanced service would require robust protocols and independent training for those involved, and would rely on effective lines of communication between healthcare professionals. AWPAG did not recommend routine monthly monitoring by pharmacists. However, community pharmacists could, as part of their requirement to carry out medicines usage reviews, be directed to concentrate these reviews on patients who are taking sip feeds and 'flag-up' patients when the length of treatment, or the volumes supplied, are inappropriate, or when non-compliance is apparent.

Substance Misusers

Substance misuse is not a specified indication for the use of sip feeds. It is preferable that patients maintain nutritional status with normal dietary measures whenever possible. Sip feeds should only be prescribed to substance misusers if it is considered to be appropriate following assessment by a registered dietitian.

Care homes

The Department of Health's [National Minimum Standards for Care Homes for Older People](#)¹⁰ and NICE state that new service users must be weighed on admission, and that their diet and dietary preferences must be assessed. During a patient's stay in a care home, nutritional screening should be carried out periodically, and a record maintained of nutrition, weight gain or loss, and any appropriate action that has been taken. All homes should have access to weighing scales which are maintained and accurate, and those which provide nursing care are expected to have sit-on scales.¹¹

NICE states that, although guidance on the provision of meals in care homes is beyond the scope of their guideline, it is clear that care homes should provide adequate quantities of good quality food if the use of unnecessary nutrition support is to be avoided. They also advise that the food should be served in an environment conducive to eating, with help given to those patients who can potentially eat but who are unable to feed themselves.³

The Care Standards Inspectorate for Wales (CSIW) do not inspect for nutritional content of menus.¹¹ Many care homes would welcome greater dietetic support to improve menu planning and methods of supplementation, fortification, or texture modification of normal diets. Care homes should identify a member of staff that could act as a nutrition link worker. (See **training** section for further information).

The use of pooled sip feeds (i.e. those which are held in a central location and not prescribed on a named patient basis) is inappropriate and should not be permitted.

Specialist assessment documentation, as completed by a registered dietitian for patients under the [unified assessment process](#)¹², should be standardised.

Further consideration could be given to the extension/provision of minimum nutrition standards to care homes.

Organisational priorities

Direct supply

Existing local arrangements for the supply of enteral and parenteral feeds in the community can include direct supply to the patient. This is not considered appropriate for oral nutritional supplements, which should be prescribed on FP10.

The ABPI Code of Practice⁵

There are concerns that the use of free samples is a major cause of inappropriate usage of sip feeds. They may discourage a 'food first strategy' and can lead to inappropriate switching between supplements which are nutritionally non-equivalent. Nutrition does not currently fall within the ABPI [Code of Practice](#).⁵

There are alternative methods of providing patients with a mixture of flavours and styles to improve compliance and waste (e.g. prescribing 'mixed flavours' or 'starter pack'). Therefore, this group strongly recommends that the pharmaceutical and nutrition industry should follow the ABPI Code of Practice regarding the supply of samples (Clause 17).⁵

The ABPI Code of Practice exempts starter packs from Clause 17. However, the code states that starter packs are designed so that a primary care prescriber can initiate treatment when there might otherwise be an unacceptable delay in commencing treatment, and that, by inference the range of products will be limited to products such as antibiotics and analgesics. As sip feeds do not meet these criteria for starter packs, Clause 17 should apply.

Procurement, premium pricing and loss leaders within NHS trusts

In Wales, sip feeds are currently prescribed on FP10 prescriptions in primary care from the ACBS list of approved products. GPs are reminded that the ACBS recommends products on the basis that they may be regarded as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.⁶

In secondary care there are three regional best buy guides that list a number of nutrition products at a reduced price, following a competitive tendering process. This process is run in conjunction with Welsh Health Supplies (WHS, formerly Welsh Health Common Services Authority). A number of hospital trusts have their own contracts in place for sip and tube feeding. When the three consortia tendered for the best buy guide they offered prices on the basis of a total nutrition package, rather than sip feeds alone. Tube feeding of adults and children is a complicated area requiring extensive service provision and this was included in the tenders.

WHS have a buying guide (framework agreement) for sip feeds which is reviewed every two years. All hospitals can purchase from it but some will negotiate further reductions by, for example, using a single supplier.

Sip feeds are not all nutritionally equivalent. When considering the procurement of sip feeds, a range of products with a variety of flavours and styles is required. This addresses variations in clinical need and patient preference, and is necessary to reduce waste. A monopoly situation that limits patient choice should be avoided.

Some trusts provide adult sip feeds from stores, whereas others provide them via the pharmacy.

The Pharmaceutical Price Regulation Scheme does not apply to nutritional products and, as products are zero discounted, they cannot be further discounted in the community, beyond the existing wholesaler discount.

Further consideration could be given to the use of loss leaders, both medications and oral nutritional supplements, and their impact on the NHS as a whole.

Training

NICE guidance advises that screening for malnutrition, or the risk of malnutrition, should be carried out by healthcare professionals with appropriate skills and training.³ The screening recommendations are extensive and it is anticipated that there will be a significant increase in the number of patients who are identified as being malnourished or at risk of malnutrition.

Training programmes for health care professionals within clearly defined guidelines, and with clear learning outcomes, will be essential to ensure that resources are appropriately focused. Anecdotal evidence suggests that community nurses and care home staff currently receive a substantial part of their training on supplementary feeding from suppliers. Training packages disseminated by dietitians are often developed with industry involvement. It is recommended that existing training packages are independently assessed and, where appropriate, accredited by trust or LHB dietitians.

Within the hospital setting, the Welsh Risk Pool (Standard 23)⁹ analyses each step in dietary provision and nutritional screening, assessment and monitoring, and is a standing item on the AWDAC agenda. Nutrition steering groups exist in many trusts. This level of organisation and infrastructure does not exist in the community.

NICE recommends that a multi-disciplinary 'community nutrition team' approach is valuable. The team should include dietitians, district nurses, and care home staff, together with other allied healthcare professionals such as speech and language therapists, physiotherapists, and occupational therapists when necessary. The team should then work with patients, relatives, carers, caterers, and GPs to prevent or treat malnutrition as appropriate. They should develop protocols and care pathways for nutrition support, along with educational initiatives to ensure that all health professionals understand the importance of nutrition in patient care.³

Because CSIW does not inspect menus for nutritional content, dietetic support to care homes is needed in order to improve menu planning and methods of supplementation/fortification of normal diets. However, there is a significant lack of community dietetic support and infrastructure.

Prescribing recommendations regarding sip feeds have been made in the BNF and WeMeReC Bulletins but these have not been widely adopted. This suggests that there may be training requirements in this area.

Actions & resources needed to comply with recommendations

Currently there is a significant lack of community dietitians and appropriately trained healthcare professionals. LHBs are advised to review the level of dietetic input to care homes. With appropriate resources, this could be provided by a combination of registered dietitians, dietetic assistants, and link workers. This approach, and establishing multidisciplinary community nutrition teams, would require additional funding. If this is dependant on local priorities without additional resources anecdotal evidence suggests that community nutritional support will, at best, remain static.

The NICE screening recommendations are extensive and a significant increase in the number of patients identified as malnourished, or at risk of malnutrition, can be anticipated. NICE states that screening should be carried out by healthcare professionals with appropriate skills and training.³ The training packages and key competencies need to be developed and agreed as a matter of urgency.

Resources

AWDAC are recommended to develop or identify the following:

- patient information leaflets.
- guidance on maximising intake from meals and snacks/food first.
- good practice advice for professionals on the storage, presentation and timing of feeds.
- a summary of types of sip feed for professionals (e.g. an update of WeMeReC⁸ Table 1).
- community monitoring charts/patient held records.

Dissemination/circulation

It is recommended that this document is circulated to the organisations on the following list. Pages two and three, headed 'Nutrition support in adults: key priorities for implementation', could be circulated more widely as deemed appropriate by those receiving the whole document.

All Wales Dietetic Advisory Committee
Chief Pharmacists
Community Dietitians
Community Health Councils in Wales
CSIW
Community Pharmacists
Community Pharmacy Wales
Directors of Nursing
Drugs and Therapeutics Committees
General Practitioners
Local Medical Committees
Trust Dietitians
Trust Nutrition Steering Groups
Trust Protocol Committees / consultants / directorates
LHB: Heads of Pharmacy Management
LHB Medical Directors
Nursing Home Association
Social Services
Welsh Health Supplies

Audit

Uptake of the key priorities within primary care may be improved by the availability of an audit pack. This could be adapted locally and also be an option within the learning portfolio aspect of the prescribing incentive scheme. AWPAG are currently collating existing audits covering a number of therapeutic areas, including nutrition support in adults.

Acknowledgements

Representatives from the following organisations contributed to this work:

All Wales Prescribing Advisory Group
NHS Industry Forum
All Wales Dietetic Advisory Committee
Bridgend Local Health Board
Denbighshire Local Health Board
Wrexham Local Health Board
Care Standards Inspectorate Wales
Welsh Medicines Partnership

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Appendix

INSERT TRUST / LHB LOGO

DEPARTMENT OF COMMUNITY NUTRITION & DIETETICS
Insert contact details

PRESCRIPTION REQUEST

Date.....

Dear Dr.

RE: Name.....D.O.B.....

Address.....

.....

Source of referral:.....

Diagnosis:.....

I would be grateful if you would approve the prescribing of ACBS items for the above patient on FP10 and endorsed 'ACBS'.

Dietetic rationale:

.....

Recommended products prescribed / weekly dosage:

.....

.....

Alternative products such as.....are also suitable.

I estimate that the patient will need to take the product(s) for a period of

.....

I have arranged to see..... in.....time.....

I have not arranged follow-up. Please review the patient / prescription within 2 / 4 / 8 / 12 weeks (delete as necessary). However, should the patient's condition change and you consider further dietetic advice necessary, please contact the department.

Yours sincerely

COMMUNITY DIETITIAN