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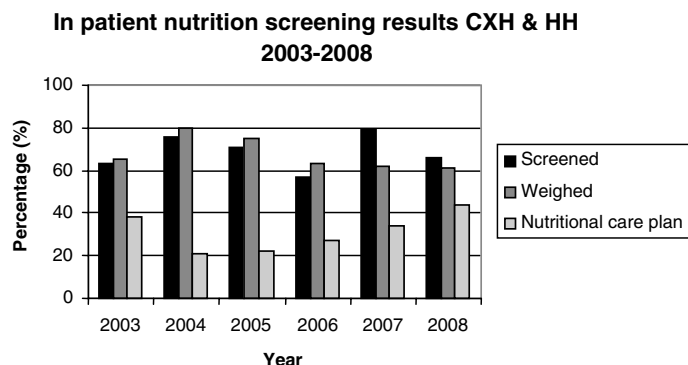
The use of the Imperial Nutritional Screening System in practice: six consecutive audits

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All hospital inpatients on admission should be nutritionally screened and screening should be repeated weekly⁽¹⁾. There is research describing the development and validation of screening tools but very little research looking at the use of the tools by nursing staff in hospital. A recent British Association for Parenteral and Enteral Nutrition (BAPEN) report suggests that weighing across all wards is carried out in only 49% of hospitals. Findings from the report also demonstrate that 66% of hospitals are still screening <50% of patients⁽²⁾. The Imperial Nutritional Screening System (INSYST) is a two-tiered screening tool that does not require BMI. It includes a pre-screen (INSYST 1; affirmation of either recent unintentional weight loss or decreased appetite) and a brief assessment carried out only if triggered by INSYST 1 (INSYST 2; detailing food intake, weight change and other risk factors; yielding 'not at risk', 'at risk' and 'malnourished' categories). Audits of the use of the INSYST tool and the proper completion of the nutritional care planning post screening have been completed from 2003 after the tool was launched across the Trust in 2002.

The audit takes place on an annual basis between January and March and is completed by each ward dietitian and the nutritional link nurse for each ward in Charing Cross Hospital (CXH) and Hammersmith Hospital (HH). Ten patients on each of the thirty-nine wards are audited randomly each month looking at the three parts of the screening process: screening (January), weekly weights (February) and whether the 'at risk' or 'malnourished' patients have a nutritional care plan (March).



The results (see Figure) show that the use of INSYST is good in relation to screening and weighing patients but there is still some work to do. Completion of care plans is poor, although it is improving consistently year-on-year. The mean completion of the INSYST tool across the two hospitals was 70 (range 48–88) %. The mean rate of weighing weekly was 69 (range 60–80) % and the mean rate for nutritional care plans for those who were identified at risk was 28 (range 18–44) %. This result is higher than the BAPEN report results, which looked at 175 hospitals. A screening policy is in place across the Trust stating that screening should occur within 48 h of admission, weekly weights are mandatory unless there is a valid reason and all patients identified at risk of malnutrition must have a nutrition care plan, yet in many wards this outcome is not achieved. A nutrition screening prize (monetary and an engraved trophy) is awarded to the best performing ward as an incentive to improve performance and this approach may have helped in certain areas. An annual programme of nutrition link nurse training is in place to ensure all nurses are adequately trained in the use of the screening system and understand the principles of nutrition support, but clearly this approach does not always lead to better care planning for malnourished patients. Particular wards do achieve 100% in each category, demonstrating that the tool can be used according to policy, yet this outcome is not achieved universally. Further work is planned to examine the reasons why 100% screening and care plan rates are not being achieved on all wards. This work shows that high screening rates do not correspond to high rates of nutritional care plans and without this vital link malnourished patients will not get the support they require. More work is urgently needed to ensure screening is linked to better nutritional care.

1. National Institute for Health and Clinical Excellence (2006) *Nutrition Support in Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition. Clinical Guideline 32*. London: NICE.
2. British Association for Parenteral and Enteral Nutrition (2008) *Nutrition Screening Survey in the UK in 2007*. Redditch, Worcs.: BAPEN.