Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Guidance for the Appropriate Use of Adult Oral Nutritional Supplements (ONS) in Primary Care

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Authors	Humber and North Yorkshire Health and Care Partnership Dietetic Leads Expert Reference Group
Document purpose	To ensure oral nutritional supplements are prescribed appropriately in adults who are at risk of malnutrition in primary care
Target audience	Primary care prescribers

This guidance has been prepared and approved for use within the Humber and North Yorkshire Health and Care Partnership by the Integrated Care Board.

Contents

Introduction

Aim

These guidelines aim to advise on the key role of food in supporting and managing malnutrition and the appropriate prescribing of oral nutritional supplements (ONS) in adults in primary care. The guidelines should be implemented to promote and facilitate standardised evidence-based practice, in line with relevant guidance published by National Institute for Health and Care Excellence (NICE).

Purpose

The guidance is intended to support health and social care professionals in the Humber and North Yorkshire Integrated Care Board (ICB), who work with people who are or may be at risk of malnutrition.

Malnutrition

What is malnutrition

Malnutrition is a state of nutrition where there is a deficiency or excess (or imbalance) of energy, protein and other nutrients. Malnutrition is commonly referred to as undernutrition.

These guidelines apply to undernutrition where there is a deficiency of nutrients to meet the body's needs.

Why is malnutrition a problem

Malnutrition affects the body systems and can result in increased susceptibility to illness, increased complications and in extreme cases even death.

- Reduced efficiency of the immune system, increasing the risk of infection and delaying recovery from illness
- Reduced muscle mass, affecting mobility, activities of daily living, respiratory function, ability to swallow safely
- Increased risk of falls
- Impaired wound healing
- Increased apathy, depression, reduced social interactions and self-neglect
- Impaired thermoregulation which can lead to hypothermia
- Increased health care costs through increased GP visits, community nursing care, hospital admissions and length of hospital stay

Who is at risk of malnutrition?

It is most common in older people over the age of 65, particularly if they are living in a care home or nursing home or have been admitted to hospital. As age and level of frailty increase, the risk of malnutrition also increases.

Groups particularly at risk of malnutrition include those with:	
Chronic disease	Chronic obstructive pulmonary disease (COPD), cancer, inflammatory bowel disease, gastrointestinal disease, renal or liver disease
Chronic progressive disease	Dementia, neurological conditions (Parkinson's disease, motor neurone disease (MND))
Acute illness	Where food is not being consumed for more than 5 days
Debility	Frailty, immobility, old age, depression, recent discharge from hospital
Social issues	Poor support, housebound, inability to cook and shop, poverty

(Managing Adult Malnutrition in the Community | Malnutrition Pathway)

How is malnutrition identified?

Nutritional risk screening should be a rapid and simple process with the outcome linked to defined courses of action. It aims to establish the level of risk of malnutrition for an individual. Screening should be carried out by professionals with appropriate skills and training.

NICE (2006) suggest that the following criteria are used for identifying individuals who are malnourished or at nutritional risk and may require nutritional support: (i.e. meet at least one of the criteria below)

- MUST (Malnutrition Universal Screening Tool; BAPEN, 2003) score of 2 or more
- BMI less than 18.5 kg/m^2
- Unintentional weight loss greater than 10% in last 3-6 months
- BMI less than 20kg/m^2 & unintentional weight loss greater than 5% in last 3-6 months
- Have poor absorptive capacity and/or high nutrient losses and/or increased nutritional need

The **Patients Association Nutrition Checklist** (2018) can be used to identify clinical concern as it has been validated against MUST and can be helpful where individuals may not be trained to screen or where formal screening is not appropriate (see appendices).

Identifying the underlying cause of malnutrition

Once nutritional risk has been established, the underlying cause of malnutrition should be assessed. The assessment process should aim to identify any social and psychological reasons as well as disease related ones, so appropriate actions can be taken. These may include advice on symptom management, referral onto support services and social prescribing. See Appendix 1 for further guidance.

How should malnutrition be treated?

NICE Clinical Guideline 32 Nutrition support for adults (2006; updated 2017): states that healthcare professionals should consider oral nutrition support to improve nutritional intake for people who can swallow safely and are malnourished or at risk of malnutrition. It defines oral nutrition support as including any of the following methods to improve nutritional intake: ''fortified food with protein, carbohydrate and/or fat, plus minerals and vitamins; snacks; oral nutritional supplements; altered meal patterns; the provision of dietary advice''.

It also advises that ''healthcare professionals should ensure that the overall nutrient intake of oral nutrition support offered contains a balanced mixture of protein, energy, fibre, electrolytes, vitamins and minerals''.

Treatment goals

In treating malnutrition, realistic and measurable goals should be established and agreed with the individual.

Set treatment goal(s) (what does the individual want to achieve?)	
Examples • Improve or maintain functional ability • Improve or maintain quality of life • Facilitate wound healing • Improve or maintain nutritional status/weight • Minimise decline in nutritional status/weight	**What to measure at each review** • Reported ability to undertake activities of daily living • Reported quality of life before & after intervention • Wound severity/size before & after intervention • Weigh & calculate Nutrition risk (MUST score) before & after intervention • Rate of weight loss/percentage of weight lost before & after intervention

What is food-based nutrition support?

A food-based approach to managing malnutrition is focused on the intake of a 'nutrient dense' diet (BAPEN, n.d.). Nutrient dense foods contain a wide range of nutrients including energy, protein, vitamins and minerals and may also contain fibre.

It is important for people who have or are at risk of malnutrition to be encouraged and enabled to eat foods from a variety of different food groups every day including:

- Starchy carbohydrates such as bread, pasta, rice, cereals or potatoes
- Protein such as meat, fish, eggs, nuts, beans/lentils, Quorn, soya
- Milk and milk containing foods such as yogurt, fromage frais or cheese
- Fruit and vegetables
- Fluid

The aim of a food-based approach is to provide about an additional 500 calories per day using food fortifiers and snacks which are naturally nutrient dense (so they all provide a range of nutrients).

Vitamin and mineral intake can be supplemented by provision of a purchased one-a-day multivitamin and mineral supplement, but this should not be thought of as an alternative to a nutrient dense diet.

What is food fortification?

Food fortification (sometimes called food enrichment) means adding extra ingredients to foods and drinks to increase their nutritional content without significantly increasing their volume or detrimentally affecting their flavour (BAPEN, n.d.). It is important to use food fortifiers (ingredients) that are nutrient dense rather than primarily providing energy (calories)-see appendix 3. When using food fortifiers which only or mainly contain calories (butter, cream) these should be used in conjunction with other more nutrient dense food fortifiers (i.e. double cream & dried skimmed milk powder).

Use of homemade supplement drinks

It is important that homemade nutritional supplement drinks contain a range of nutrients, so that they can play a key role in the treatment of malnutrition. Homemade supplements can be used for individuals at high risk of malnutrition where they/their carers are able to prepare them. Different versions can be made to meet an individual's likes/dislikes and needs, e.g. milkshake style, fruit juice style and vegan.

Over the counter oral nutritional supplements (OTC)

Some over the counter (OTC) nutritional supplements are available in larger supermarkets and pharmacies. They can provide a good source of calories and protein but may not be nutritionally complete. These should be used alongside food-based approaches. Aim for 250-330 calorie per portion twice daily.

When should standard adult Oral Nutritional Supplements (ONS) be prescribed?

What are ONS?

Oral Nutritional Supplements (ONS) are sterile liquids, semi-solids or powders, which provide macro and micronutrients. The role of ONS is to complement nutritional intake, and simultaneous information around improving oral intake should be provided.

Some ONS are available to buy over the counter in supermarkets or pharmacies (usually in powder form which are mixed with milk or water) but the majority of ONS are only available on prescription. ONS often contain macronutrients (protein and/or energy) and micronutrients (vitamins and minerals) at varying levels of concentrations. Therefore, not all ONS are nutritionally complete, meaning that they cannot be used as a sole source of nutrition.

ACBS criteria

ONS use must be approved by the Advisory Committee on Borderline Substances (ACBS; NHS Business Authority, n.d). Indications for use include:

♦ Short bowel syndrome ♦ Dysphagia ♦ Intractable malabsorption ♦ Pre-operative preparation of undernourished patients	♦ Inflammatory bowel disease ♦ Total gastrectomy ♦ Bowel fistulae ♦ Disease related malnutrition (chronic/acute

When is it appropriate to prescribe an ONS?

- ♦ Individual meets ACBS criteria for that prescribed product
- ♦ Individual is high risk of malnutrition AND evidence suggests that a food-based nutrition support approach is not possible, e.g. not possible for individual to consistently use food fortification and/or homemade nutritional supplements.

Or

- ♦ Individual is at high risk of malnutrition AND not meeting **treatment goal(s)** after 1 month **food-based** treatment & homemade or OTC supplements AND evidence suggests more likely to take a therapeutic dose of prescribed ONS compared with homemade or OTC supplement

Which standard ONS to prescribe?

Only green coded ONS products may be initiated in primary care (prescribe a 1 week supply initially, then prescribe monthly as acute script).

	Criteria	**ONS product** Therapeutic dose = 2 per day	**Care home resident**
✓ ✓ ✓	**Person/carer can prepare powder ONS** Person can manage 2 x 200ml per day Likes sweet, milky drinks	Food-based advice & **1st line Powdered ONS**	Advise staff to offer 'homemade fortified milkshake' 2 per day
If cannot manage volume- *Use powdered compact ONS*			
✓ ✓ ✓	**Person/carer cannot prepare powder ONS** Person can manage 2 x 200ml per day Person likes sweet, milky drinks	Food-based advice & **2nd line Ready to drink milk based ONS**	Advise staff to offer 'homemade fortified milkshake' 2 per day
If cannot manage volume- *Use compact ready to drink milk based ONS*			
✓ ✓ ✓ ✓	**Person is vegan** Person/carer can prepare powder ONS Person can manage 2 x 200ml per day Likes sweet drinks	Food-based advice & **2nd line powdered vegan ONS** *(Ready to drink version if unable to prepare powder version)*	Advise staff to offer 'homemade fortified vegan milkshake' 2 per day

✓ ✓ ✓	**Person does not like milky drinks** Person can manage 2 x 200ml per day Person likes sweet drinks	Food-based advice & **2nd line Fruit juice based ONS**	Advise staff to offer 'homemade fortified fruit juice' 2 per day

Other ONS can be prescribed if requested by a Dietitian:

Prescription requests must include:

- Clear clinical justification for product choice
- Length of prescription
- Goal/aim of ONS treatment
- Review plan

Standard adult ONS- Green coded products

FIRST LINE = Powdered ONS choices – preferred choice that should be prescribed if not contraindicated

Contraindications:

- **Limited dexterity & inability to prepare**
- **Cow's milk allergy or intolerance**
- **Under 6 years old**
- **Galactosaemia**
- **Not suitable for enteral feeding tubes**
- **Individuals with renal disease should be assessed by a Dietitian prior to prescribing a powdered ONS**

Presentation	Product name	Serve size	energy/serve	Protein/serve	How to prescribe
Milk-based Powder					
Complan Shake	Nutricia	57g	381kcal (with 200ml whole milk)	16g (with 200ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Aymes Shake	Aymes	57g	Typically 383kcal (with 200ml whole milk)	19g (with 200ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Foodlink Complete	Nualtra	57g	383kcal (with 200ml whole milk)	19g (with 200ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Ensure Shake	Abbott	57g	386kcal (with 200ml whole milk)	17g (with 200ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Aymes Shake Compact	Aymes	57g	Typically 320kcal (with 100ml whole milk)	15g (with 100ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Foodlink Complete Compact	Nualtra	57g	318g (with 100ml whole milk)	15g (with 100ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days
Ensure Shake	Abbott	57g	319kcal (with 100ml whole milk)	14g (with 100ml whole milk)	Dosage:57g twice a day Quantity:56 sachets =3,192g Duration: 28 days

SECOND LINE – only to be prescribed if the 1st line ONS are contraindicated or there are specific food preferences or tolerance concerns					
Presentation	**Product name**	**Serve size**	**energy/serve**	**Protein/serve**	**How to prescribe**
Ready to drink milk-based milkshake style					
Altraplen Energy	Nualtra	200ml	300kcal	12g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Actagain 1.5 Complete	Aymes	200ml	300kcal	14g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fortisip Bottle	Nutricia	200ml	300kcal	12g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Ensure Plus	Abbott	200ml	300kcal	13	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fresubin Energy	Fresenius Kabi	200ml	300kcal	11g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
If cannot manage volume, consider compact version below:					
Compact ready-to-drink milk-based ONS					
Fresubin 2kcal Mini	Fresenius Kabi	125ml	250kcal	13g	Dosage:125ml twice a day Quantity:56 bottles =7000ml Duration: 28 days
Fortisip Compact	Nutricia	125ml	300kcal	12	Dosage:125ml twice a day Quantity:56 bottles =7000ml Duration: 28 days
Ensure Compact	Abbott	125ml	300kcal	13g	Dosage:125ml twice a day Quantity:56 bottles =7000ml Duration: 28 days
Compact daily ready-to-drink milk-based ONS					
Altraplen Compact Daily	Nualtra	250ml	600kcal	24g	Dosage:250ml once a day Quantity:28 bottles =7000ml Duration: 28 days
Actagain 2.4 Daily	Aymes	250ml	600kcal	24g	Dosage:250ml once a day Quantity:28 bottles =7000ml Duration: 28 days
Plant based (vegan)					
Plant-based powdered ONS					
ActaSolve Smoothie	Aymes	66g	Typically 297kcal	11g	Dosage:66g twice a day Quantity:56 sachets =3,696g Duration: 28 days
Foodlink Smoothie	Nualtra	66g	301kcal	10g	Dosage:66g twice a day Quantity:56 sachets =3,696g Duration: 28 days
Plant based ready-to-drink ONS					

Actagain 1.5 Plant Powered	Aymes	200ml	300kcal	13g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fortisip Plant-Based 1.5kcal	Nutricia	200ml	300kcal	12g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fresubin Plant-Based Drink	Fresenius Kabi	200ml	300kcal	15g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fruit juice based ready-to-drink ONS					
Fortijuce	Nutricia	200ml	300kcal	8g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Actagain 1.5 Juce	Aymes	200ml	300kcal	10g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Altrajuce	Nualtra	200ml	300kcal	8g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Fresubin Jucy	Fresenius Kabi	200ml	300kcal	8g	Dosage:200ml twice a day Quantity:56 bottles =11,200ml Duration: 28 days
Ensure Plus Juce	Abbott	220ml	330kcal	11g	Dosage:220ml twice a day Quantity:56 bottles =12,320ml Duration: 28 days

Ready to serve dessert style ONS

Ready to serve dessert style ONS should **not** be prescribed in primary care. Dessert style ONS contain less nutrition than compact powder milkshake, powder dessert or compact ready to serve ONS and can cost considerably more.

Commencing an ONS prescription

ONS prescribing algorithm for first prescription or where change in product or flavour is indicated.

Select FIRST LINE product category

(i.e. most cost-effective option) for the individual. In most cases this will be powder-based shake-style ONS.

Prescribe "ready to drink" ONS only if meets contraindications for powder-based shake style.

If requires thickened fluids, advice should always be sought from a Dietitian or Speech and Language Therapist.

Trial selected product:

GP practices-prescribe 1 week prescription

Dietitians have the option of using free 'direct to patient ' ONS sample services. These are available online via nutritional company websites. Patient must have been consented for use.

Get feedback from the patient:

which product and flavour they like and tolerate. If the patient is requested to respond with their preferences (e.g. via AccuRx link), this feedback should be fed into patient review and ongoing prescribing of a suitable product.

Prescribe:

1 sachet or bottle TWICE daily (unless a 250ml daily ONS used), between or after meals (not 'when required') for ONE MONTH (total quantity: 28-56 sachets/bottles) as (recurrent) ACUTE PRESCRIPTION

Key principles of ONS prescribing:

Key principles of ONS prescribing	
✓	ONS should be taken **between** or **after** meals (not before meals or as a meal replacement) to maximise their effectiveness and avoid spoiling appetite.
✓	ONS should be prescribed **twice daily (600 kcal),** unless advised otherwise by a dietitian, or **once if it's a 'daily'** ONS . This ensures that nutritional intake is sufficient to achieve weight gain. Do not prescribe ONS "when required" (PRN) as this will not be of therapeutic benefit.
✓	Choose the **most cost-effective** option at the time of prescribing. First line products are **powdered shake-style supplements.**
✓	**A one-week prescription** should always be issued initially to assess tolerance/flavour preference and wastage in case products are not well tolerated or the individual doesn't like them.
✓	Once the individual has chosen which product suits them best, further acute prescriptions can be issued on a monthly basis (rather than on repeat). Prescribing quantities should therefore be (at twice daily dosing) 56 sachets or bottles per 4 weeks (unless 'daily' type ONS, then 28 bottles/4 weeks).
✓	ONS should normally be prescribed as an 'acute' prescription. Do not add ONS prescriptions to the repeat template unless a review date is included to ensure review against goals. Appropriate systems should be used to highlight when a review is due and ensure prescriptions are not continued inappropriately.
✓	Individuals and their carers should be made aware that any ONS drink that is not finished on the sitting (around two hours) can be stored in the fridge for up to 24 hours and consumed later in the day to avoid wastage.
✓	There are some larger volume ready-to-drink products available (e.g. Nualtra Altraplen Compact Daily 250ml & Aymes ActaGain 2.4 Daily 250ml drinks) designed to be taken once daily, this can reduce waste and support adherence.
✓	**CAUTION:** Please note that some ONS products may not be suitable for patients requiring thickened fluids. When patients require thickened fluids, advice should always be sought from a Speech and Language Therapist, Dietitian, or relevant clinician.
✓	If prescribing ONS to any heavy alcohol user with malnutrition, consider additional prescription of thiamine (oral or IM) to prevent Wernicke's encephalopathy. Also see appendix on refeeding guidance

Taken with permission from NHS North East and North Cumbria ICB ONS guidance (2024) and adapted.

NOTE: Where someone is vegan, has a cow's milk protein allergy, or follows a cultural/religious diet, particular attention should be paid to the ingredients of the ONS product. There are a variety of ONS available that are suitable for those that are vegan and the majority of supplements are halal, gluten and low lactose/lactose free.
Specific product information can be found on the below ONS company websites:
Nutricia Products | Product Guide | Nutricia UK.
Ready to Drink Range
Ensure® Products | Meal Replacement Shakes & Nutrition Drinks
Products – Nualtra
Innovative Nutritional Supplements - AYMES Nutrition

Prescribing ONS in Care Homes

Adults in care homes should be screened for malnutrition on admission and repeated monthly or when there is clinical concern with a validated nutritional screening tool (e.g. MUST).

The Health and Social Care Act 2008 Regulations 2014: Regulation 14 Meeting Nutrition and Hydration Needs clearly states that the nutritional and hydration needs of service users must be met where care and treatment involve:

“Provision of accommodation by the service provider, or an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.”

Regulation 14 also states that: “A variety of nutritious, appetising food should be available to meet people’s needs. Food based nutrition support should be utilised for all ‘at risk’ residents and ONS should only be prescribed where there is a clear clinical justification" i.e. that the individual meets the prescribing criteria and there is evidence that food-based nutrition advice, including the use of homemade nutritional supplement drinks, has resulted in no improvement. ONS should not be routinely prescribed for care home residents unless in exceptional circumstances and as directed by a Dietitian.

Reviewing ONS prescription

Following initial prescription, ONS should be reviewed after 4 weeks, if not feasible a review should take place at least every 3-6 months, to determine level of improvement, ensure ONS treatment remains appropriate and being taken as prescribed. The following should be considered during reviews:

- Weight and nutrition risk score (e.g. MUST score)
- Treatment goals of ONS intervention
- Check compliance with food-based approaches
- Check compliance with ONS treatment twice daily (signs of stock piling, disliking flavours)
- Consider if referral for specialist dietetic advice required

Discontinuing ONS prescription

Providing that prescriptions for ONS are initiated with a clear and patient-agreed goal, it should be easy to identify the point at which ONS can be stopped. When treatment goals are met prescriptions for ONS should be discontinued or weaned off:

- If weaning off –reduce by 300kcal/day per month i.e. if 2 doses of ONS per day (600kcal per day), reduce dose to once daily (300kcal per day)
- food-based nutrition advice maintained / increased where necessary to meet deficit from reducing ONS
- ideally, review one month after discontinuation of ONS to ensure that there is no recurrence of the precipitating problem.
- If there are concerns regarding the quality of the diet, consider advising the patient to purchase an OTC ‘complete A-Z multivitamin and mineral’ supplement.

ONS prescribing across pathways of care

Specialist Dietetic input

Dietitians are skilled in assessing an individual’s diet, nutritional intake, appetite and ability to act on advice, considering underlying medical condition(s) and psychosocial circumstances. The referral criteria may differ for specific localities, so check with the local service.

Individuals with complex nutritional needs, e.g. swallowing problems, poorly controlled diabetes, progressive neurological and gastrointestinal disorders may require specialist products and should be referred for specialist dietetic advice. Patients already being treated for an underlying disorder by a hospital consultant may already be under the care of the hospital dietitians as part of the Multidisciplinary team (MDT).

ONS prescription requests on discharge from secondary care

Individuals admitted to secondary care should be screened for malnutrition and those identified to be at high risk should be provided with first line nutritional support. Individuals that meet criteria for specialist dietetic input (refer to local guidance) are referred to the hospital dietetic services. If patients are seen by the dietetic service whilst in hospital and recommended on-going use of ONS on discharge, the dietitian will communicate this to the GP practice. Therefore, if a patient is discharged from hospital with ONS on prescription and there is no subsequent communication from the dietitians, it can be assumed that the ONS were not initiated by the dietetic team and therefore may be inappropriate to continue (when measured against prescribing guidelines).

To prevent inappropriate prescribing of ONS in primary care, GP practices are advised to stop prescribing ONS if they are included on the hospital discharge letter but there is no subsequent communication from the dietitians. Where there is a clinical concern, GP practices should screen the patient for risk of malnutrition and follow this guidance accordingly.

ONS prescription requests from other Healthcare professionals

All health professionals should communicate their requests for ONS prescriptions to GP practices clearly, timely and include the following information:

- Anthropometric data (weight, height, BMI, weight loss history)
- The clinical indication for ONS (evidence of disease-related malnutrition / ACBS prescribing criteria)
- Daily dose & a clear nutritional goal
- Duration / expected duration
- Review plan

Specialist/complex areas

Dysphagia/ Speech and Language Therapy (SALT) input

Individuals presenting with dysphagia should be referred to a Speech and Language Therapist for specialist assessment, intervention and advice. The International Dysphagia Diet Standardisation Initiative (IDDSI) framework (2019) provides a common terminology for describing food textures and fluid thicknesses to improve safety for individuals with swallowing difficulties. ONS products vary in consistency and do not thicken well, thus may be unsafe for the individual with dysphagia. Individuals at risk of malnutrition should be referred to local dietetic teams for specialist advice on suitable food-based nutrition support for texture modified diets and appropriate ONS (if indicated), as per SALT recommendations.

Palliative/End of life care & treatment of malnutrition

Before prescribing ONS in palliative care, the individual's prognosis, treatment plan and quality of life should be carefully considered. Nutrition related symptoms should be identified and treated appropriately (i.e. nausea, dry mouth, breathlessness, taste changes). In early palliative care where an individual has a prognosis of months or years, nutritional screening, assessment and treatment should be followed as outlined earlier in this guidance.

In end-of-life palliative care, where an individual is deteriorating and prognosis is weeks/days, the use of ONS is unlikely to improve nutritional status or prolong life. Reassurance and support should be given to the individual and carers that loss of appetite and weight loss are expected in advanced disease. Nutritional care should focus on enjoyment of food and drinks, symptom relief and comfort, alleviating the pressure on the patient to maintain a

normal diet, therefore it may not be appropriate to commence or continue ONS. A helpful leaflet is available from the British Dietetic Association: Carer information: Eating and drinking at the end of life (2020).

Chronic Kidney Disease (CKD)

ONS should be used with caution in individuals with CKD stage 3 and only following Dietitian recommendation for CKD stage 4 and 5.

Diabetes

Individuals with diabetes who are malnourished or at risk of malnutrition should aim to optimise both nutritional status and blood glucose control. Treatment of malnutrition however may take priority over optimising blood glucose control depending on the diagnosis, prognosis and degree of malnutrition. Following a significant change in oral intake or use of ONS, blood glucose levels may need to be monitored more closely, and diabetes medications reviewed and titrated as required.
'Juice' based ONS should not be routinely prescribed for individuals with diabetes. Milk based ONS are preferable due to their lower Glycaemic Index.

Warfarin/Vitamin K

For individuals on Warfarin therapy, inconsistent intakes of Vitamin K can affect INR (International Normalised Ratio) levels and the way that Warfarin works. It is important therefore, to aim to have daily consistent intake of Vitamin K. ONS products contain varying levels of Vitamin K. Individuals who start, change or stop ONS whilst on Warfarin therapy should be advised to discuss this with their GP or appropriate healthcare professional. INR levels may need to be checked more frequently, to monitor Warfarin dosage.

References:

British Association for Parenteral and Enteral Nutrition (BAPEN) (2003) Malnutrition Universal Screening Tool (MUST). Revised 2003. Available at: https://www.bapen.org.uk/pdfs/must/must_full.pdf (Accessed: 8 December 2025).

British Association for Parenteral and Enteral Nutrition (BAPEN) (n.d.) Food first: food enrichment. Available at: https://www.bapen.org.uk/education/nutrition-support/nutrition-by-mouth/food-first-food-enrichment/ (Accessed: 8 December 2025).

British Dietetic Association (BDA) (2020) Carer information: Eating and drinking at end of life. BDA-End-of-life-nutrition-300320-v1.pdf. Available at: https://patientwebinars.co.uk/wp-content/uploads/2020/05/BDA-End-of-life-nutrition-300320-v1.pdf (Accessed: 8 December 2025).

Care Quality Commission (CQC) (2014) Regulation 14: Meeting nutritional and hydration needs. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-14#:~:text=The%20intention%20of%20this%20regulation,they%20receive%20care%20and%20treatment (Accessed: 8 December 2025).

International Dysphagia Diet Standardisation Initiative (IDDSI) (2019) IDDSI framework. Available at: https://www.iddsi.org/standards/framework (Accessed: 8 December 2025).

Malnutrition Pathway (2021) Managing adult malnutrition in the community. 3rd edn. Available at: https://www.malnutritionpathway.co.uk/library/managing_malnutrition.pdf (Accessed: 8 December 2025).

National Institute for Health and Care Excellence (NICE) (2006) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (CG32). Updated 2017. Available at: https://www.nice.org.uk/guidance/cg32 (Accessed: 8 December 2025).

NHS Business Services Authority (NHSBSA) (n.d.) Drug Tariff: Part XV – Borderline substances. Available at: https://www.drugtariff.nhsbsa.nhs.uk/#/00814419-DC/DC00814008/Part%20XV%20-%20Borderline%20Substances (Accessed: 8 December 2025).

Patients Association (2018) Patients Association Nutrition Checklist Toolkit. Updated 2023. Available at: https://www.patients-association.org.uk/patients-association-nutrition-checklist-toolkit (Accessed: 8 December 2025).

North East and North Cumbria ICB; Guidelines for the appropriate prescribing of oral nutritional supplementation in the management of adults at risk of undernutrition in primary care: 2024

Other Useful Resources:

Malnutrition Pathway Primary Care Networks Portal | Welcome

Appendices:

Appendix 1: Quick guide: Adult oral nutritional supplement (ONS) prescribing in primary care

Establish if at risk of malnutrition?:

- Weigh individual, obtain height & weight history over approximately last 3-6 months
- Screen with a validated tool – e.g. calculate MUST (Malnutrition Universal Screening Tool)

Assess causes of malnutrition & any actions required

- Disease, disorder or medical condition- provide disease related advice, treat symptom e.g. nausea, vomiting, constipation, pain
- Social- consider referral to social prescriber, access to food/shopping, use of food banks, luncheon clubs, Food delivery services, social/support groups, family involvement & refer to appropriate services
- Support with anxiety/depression & refer to appropriate services
- Dental- ensure good oral hygiene, advise on dental care

<table>
<tr><th colspan="3">Nutrition Action Plan</th></tr>
<tr><th>Risk</th><th>Intervention</th><th>Monitoring</th></tr>
<tr><td>Low risk:
MUST =0
BMI >20 & <5% unplanned weight loss in last 3-6 months</td><td>None needed</td><td>Routine</td></tr>
<tr><td>Medium risk:
MUST =1
BMI 18.5-20
5-10% unplanned weight loss in last 3-6 months</td><td>Establish treatment goal(s)*
Treat using food-based advice
Use food-based resource</td><td>Review-ideally monthly-record
Progress against treatment goal
Weight
BMI
MUST score
If treatment goal(s) being met, continue until appropriate to stop</td></tr>
<tr><td colspan="3">If treatment goal for Medium risk not being met, consider treating as High risk</td></tr>
<tr><td>High risk:
MUST=2-6
BMI<18.5
10% unplanned weight loss in last 3-6 months
BMI<20 & >5% unplanned weight loss in last 3-6 months</td><td>Establish treatment goal (s)*
Treat using food-based advice
Use food-based resource
Advise use of Homemade supplements
Or OTC supplements</td><td>Review-ideally monthly-record
Progress against treatment goal
Weight
BMI
MUST score
If treatment goal(s) being met, continue until appropriate to stop

If treatment goal not being met, consider whether a prescribed ONS is more likely to be taken than a homemade supplement or OTC supplement? (If not, ONS prescription unlikely to be appropriate, regardless of level of malnutrition)</td></tr>
<tr><td colspan="3">High risk- refer to dietitian only if meets Dietetic referral criteria</td></tr>
</table>

Set treatment goal (s) (what does the individual want to achieve?)	
Examples: • **Improve or maintain functional ability** • **Improve or maintain quality of life** • **Facilitate wound healing** • **Improve or maintain nutritional status/weight** • **Minimise decline in nutritional status/weight**	**What to measure at each review** • **Reported ability to undertake activities of daily living** • **Reported quality of life before & after intervention** • **Wound severity/size before & after intervention** • **Weigh & calculate MUST score before & after intervention** • **Rate of weight loss/percentage of weight lost before & after intervention**

When is it appropriate to prescribe an ONS?

- ♦ Individual meets ACBS criteria for that prescribed product
- ♦ Individual is high risk of malnutrition AND evidence suggests that they/carer is unable to prepare homemade or OTC supplements

Or

Individual is at high risk of malnutrition AND not meeting **treatment goal(s**) after 1 month **food-based treatment** & homemade or OTC supplements AND evidence suggests more likely to take a therapeutic dose of prescribed ONS compared with homemade or OTC supplemen**t**

Which standard ONS to prescribe? – always start with the **1st line green coded ONS products**, when initiating a prescriptions in primary care, unless there are contraindications, specific food preferences or tolerance concerns and then prescribe the most suitable **2nd line green coded ONS product**. Please refer to the ONS tables on p6/7 in the document for full guidance.
(prescribe a 1 week supply initially, then prescribe monthly as acute script**)**

	Criteria	**ONS product** Therapeutic dose = 2 per day	**Care home resident**
✓ ✓ ✓	**Person/carer can prepare powder ONS** Person can manage 2 x 200ml per day Likes sweet, milky drinks	Food-based advice & **1st line Powdered ONS**	Advise staff to offer 'homemade fortified milkshake' 2 per day
If cannot manage volume- *Use powdered compact ONS*			
✓ ✓ ✓	**Person/carer cannot prepare powder ONS** **Person can manage 2 x 200ml per day** **Person likes sweet, milky drinks**	Food-based advice & **2nd line Ready to drink milk based ONS**	Advise staff to offer 'homemade fortified milkshake' 2 per day
If cannot manage volume- *Use compact ready to drink milk based ONS*			
✓ ✓ ✓ ✓	**Person is vegan** **Person/carer can prepare powder ONS** **Person can manage 2 x 200ml per day** **Likes sweet drinks**	Food-based advice & **2nd line powdered vegan ONS** *(Ready to drink version if unable to prepare powder version)*	Advise staff to offer 'homemade fortified vegan milkshake' 2 per day
✓ ✓ ✓	**Person does not like milky drinks** **Person can manage 2 x 200ml per day** **Person likes sweet drinks**	Food-based advice & **2nd line Fruit juice based ONS**	Advise staff to offer 'homemade fortified fruit juice' 2 per day
Other ONS can be prescribed if requested by a Dietitian - they must provide clinical reasoning			

Stop prescribing an ONS when any of the following apply:

- When treatment goal(s) are met
- When person has met target BMI and is gaining weight
- When requested to do so by Dietitian

- When person is unable/unwilling to take ONS as a therapeutic dose (2 per day)-consider if alternative
- When person is reaching end of life, continuing to try & take ONS is likely to reduce quality of life

Acknowledgement: Hertfordshire & West Essex ICB: Alison Smith- Prescribing Support Consultant Dietitian

Assessment of underlying causes of malnutrition

The assessment process enables a specific treatment plan to be developed for the individual. It aims to identify any underlying causes of malnutrition and any possible interventions that need to be taken.

Medical conditions causing poor appetite e.g. nausea, breathlessness, constipation, diarrhoea, poorly controlled diabetes, cancer etc.	GP management, Community Nursing Team, Palliative Care team, appropriate medication
Poor oral health e.g. dry, sore mouth, altered taste, ulcers, poor dentition /ill-fitting dentures	Consider referral to Dentist and advise on soft/appropriate diet, appropriate medication
Difficulties or unable to swallow	Investigate cause and treat ability to chew/swallow. Consider referral to Speech and Language Therapist for feeding/swallowing assessment
Poor emotional or mental health e.g. low mood, anxiety, self-neglect, bereavement, alcoholism, addictions	GP management, counselling Consider referral to appropriate Mental Health Services, social clubs, day centres
Disabilities e.g. visual problems affecting cooking & feeding skills, difficulties in preparing, eating or handling food	Consider referral to Optician Consider referral to Occupational Therapist
Social issues e.g. living conditions, isolation, needs help to plan, shop, prepare, cook meals	Consider Social Services referral (for benefit entitlement, housing, for **signposting advice** or assessment, meals on wheels, home care, day centre, luncheon clubs)
Poly-pharmacy – side effect of medication on appetite, GI function, micronutrient absorption	Clinical medication review or medicines use review e.g. pharmacy

Audit tool- ONS review in GP practice- supporting guidance

Step	Action / Guidance
1	Run ONS search. - EMIS Web: Search for all patients with ONS as a current prescription (acute or repeat), regardless of issue date. - SystmOne: Search for all patients issued ONS within the last 6 months.
2	Check if ONS issued in last 3 months. - If not, patient review required prior to re-issue. This prevents unreviewed repeat prescribing.
3	If ONS for tube feeding (NG, PEG, RIG): - Verify product, quantity, and frequency match dietitian's request. - Inform dietitian if discrepancies found. - Ensure prescriptions are sent to enteral feed company unless specified
4	For other patients, review the following: a. Recent weight/BMI (within 3 months). b. Nutrition risk screening score c. Treatment goals and progress monitoring. d. Food-based advice given. e. If product justification is documented f. Therapeutic dose stated (usually 2/day). g. Correct quantity prescribed (56 bottles or sachets per 28 days). h. Monthly issue frequency. i. Review plan in place. j. If dietitian involved, check product/dose match and ongoing involvement. → If complete, assess ongoing ONS need → If incomplete, arrange internal review to gather missing data (not dietitian referral).
6	If, after completing the above, you are **unsure how to manage specific patients**, please contact your local community dietetic team for advice, who will be happy to discuss with you and/or the practice to advise on the best way forward.
7	Discuss your findings with the prescriber and advise what prescription changes need to be made/communicated to patients by practice staff.
8	Ideally, repeat ONS search every 6 months

Appendix 2: Refeeding Syndrome

Refeeding syndrome (RFS) is the group of clinical symptoms which can occur when introducing nutrition to a malnourished or starved individual. RFS can be described as either **biochemical refeeding syndrome**, where electrolyte imbalances occur without clinical symptoms, or **symptomatic refeeding syndrome**, where both biochemical abnormalities and clinical symptoms are present.

During Malnutrition or Starvation

In the absence of adequate dietary intake, the body switches from using carbohydrates as its main energy source to relying on fat and protein store and gluconeogenesis occurs. As fat and muscle tissue are broken down, body weight decreases, and lean body mass is lost. Prolonged starvation results in depletion of intracellular minerals (especially phosphate, potassium, and magnesium), along with reduced stores of vitamins and water. Despite these intracellular losses, serum levels may appear normal until feeding resumes.

During Refeeding

When feeding commences, carbohydrate intake increases, leading to a rapid rise in blood glucose levels. The body responds by releasing insulin, which promotes cellular uptake of glucose, potassium, phosphate, and magnesium, and stimulates protein synthesis. This insulin-driven process causes a rapid intracellular shift of phosphate, magnesium, and potassium, leading to potentially severe drops in their plasma concentrations. Thiamine demand increases, as it acts as a crucial coenzyme in carbohydrate metabolism. Without adequate replacement, thiamine deficiency can lead to complications such as Wernicke's encephalopathy. These combined changes can trigger the biochemical and clinical manifestations of refeeding syndrome (RFS).

Main Features of Refeeding Syndrome

- Fluid retention – due to sodium and water imbalance, leading to oedema and possible heart failure.
- Altered glucose metabolism – hyperglycaemia may develop as metabolism shifts back to carbohydrate dependence.
- Hypophosphataemia – caused by cellular phosphate uptake, leading to muscle weakness, respiratory failure, or arrhythmias.
- Hypomagnesaemia – resulting in tremors, seizures, or cardiac arrhythmias.
- Hypokalaemia – due to intracellular potassium shifts, which can cause cardiac and neuromuscular complications.

Due to the potential severe consequences of refeeding syndrome health professionals need to aim for prevention in refeeding at risk patients. Nutritional treatment of patients at risk of RFS should be provided by healthcare practitioners with adequate training in Nutrition Support (NICE 2006). Management of RFS in primary care should always be in partnership with the GP. Patients need to be treated individually and practically where Nutrition Support (NICE 2006) guidance is applied, as best appropriate to the patient's situation.

Patients at risk of RFS:

Patients at Risk of developing Re-feeding Syndrome
Any patient who has had very little or no food intake for >5 days

Patients at High Risk of developing Re-feeding Syndrome
A patient has 1 or more of the following:
BMI (Body Mass Index) less than 16kg/m²
Unintentional weight loss greater than 15% within the last 3–6 months
Very little or no nutritional intake for more than 10 days
Low levels of potassium, phosphate or magnesium prior to feeding
OR a patient has 2 or more of the following:
BMI less than 18.5kg/m²
Unintentional weight loss greater than 10% within the last 3–6 months
Little or no nutritional intake for more than 5 days
A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics

Patients at Extremely High Risk of developing Re-feeding Syndrome
BMI less than 14kg/m²
Very little or no nutrition for greater than 15 days

Managing RFS in the community setting

Ideally, serum electrolytes should be monitored throughout the refeeding period; however, this can be challenging to implement within the primary care setting. Patients identified as being at **high risk** of RFS should be referred directly to a dietitian for specialist advice and management.

The balance of refeeding syndrome risk and the risk of ongoing underfeeding and undernutrition through undue delaying of nutritional support needs to be considered.

For patients discharged from secondary care on a refeeding pathway, dietetic recommendations outlined in the discharge summary must be followed closely, particularly regarding feeding regimens, and electrolyte, nutrient, and vitamin replacement.

Appendix 3: Food-based Nutritional Support Leaflet

ICB - 500kcal 20g protein (4) (1).pdf

Appendix 4: Homemade Supplement Drinks

ICB - Homemade Supplement Drinks (3)