



Nutrition Care in the Emergency Department: A Neglected Window for Screening the Frail Older Patient

Colm Hegarty^{1*}, Anja Weissenbach² and Kristine Bjelke³

¹Department of Emergency Medicine, Slieve Bloom Institute of Human Nutrition, Tullamore, Ireland

²Department of Nutrition and Dietetics, Vorarlberg Institute of Nutritional Medicine, Bregenz, Austria

³Department of Geriatric Medicine, Nordland Institute of Clinical Nutrition, Bodo, Norway

*Correspondence to: Colm Hegarty, Department of Emergency Medicine, Slieve Bloom Institute of Human Nutrition, Tullamore, Ireland

E-mail: c.hegarty@sbihn.ie

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Abstract

The emergency department sees more older adults than any other point of contact, and nutritional risk is common among them. In 353 older adults screened at one Irish emergency department with the Mini Nutritional Assessment short form, mean age 79.6 years, 7.6 per cent were malnourished and a further 28 per cent were at risk. Those malnourished at the visit had poorer quality of life and functional ability, were more frail, and at 30 days were more likely to report another hospital admission, a nursing home admission, reduced quality of life and functional decline. The complication is what the phrase neglected window identifies. A scoping review of 19 studies found that nutrition care reported in emergency departments is largely limited to screening, with full assessment, recorded diagnosis and intervention often absent, and screening formed part of a comprehensive geriatric assessment in only 9 of the 19. How many patients are found also depends on the instrument, with nutritional risk reported at 41.5 per cent using a tool that incorporates illness severity. The neglected part of the window is not the screening.

Keywords: Emergency department; Malnutrition screening; Older adults; Frailty; Care pathways

Introduction

Older adults attend emergency departments more than any other age group, and many who attend are frail, live alone or have recently been in hospital [1,2,3]. The department therefore sees a population at high nutritional risk that is otherwise difficult to reach, and it sees them at a moment when something could be initiated [2,4].

That observation has produced a substantial literature arguing for nutrition screening in the emergency department, and screening does take place in many of them [4,5]. Whether it leads anywhere is a separate question, and it is the one this review is concerned with [5,6].

The argument examined here is not whether nutritional risk is present, which is established, but whether the window is neglected in the way the phrase implies.

Objective

This review sets out to establish four things from the published literature. First, what prevalence of malnutrition and nutritional risk is found among older adults in the emergency department. Second, how much that finding depends on the instrument used. Third, what happens after a positive screen. And fourth, where in the pathway the evidence indicates the failure actually lies.

Literature Review

What is found when older adults are screened: A secondary analysis of a randomised trial screened 353 older adults presenting to an Irish emergency department using the Mini Nutritional Assessment short form [7]. Mean age was 79.6 years (SD 7.0) and 59.2 per cent, 209 patients, were women. Malnutrition was present in 7.6 per cent, 27 patients, and a further 28 per cent, 99 patients, were classified at risk of malnutrition [7]. More than a third of those attending therefore fell into one of the two categories.

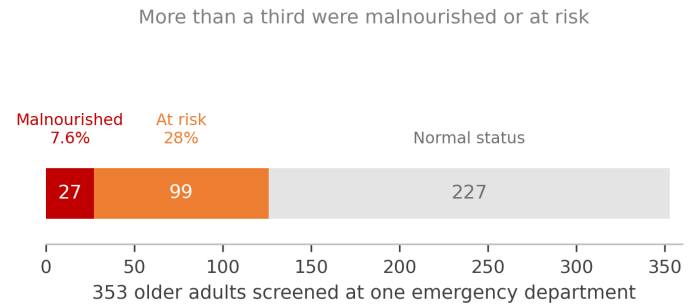


Figure 1: Nutritional status of 353 older adults screened at one emergency department [7]

The finding predicts what follows: At the index visit, those who were malnourished had poorer quality of life scores and functional ability, were more frail, were more likely to have been hospitalised or to have fallen recently, had longer waiting times, and were more likely to be discharged home from the department than those with normal nutritional status [7]. At 30 days they were more likely to report another hospital admission, a nursing home admission, reduced quality of life and functional decline [7]. The combination of being discharged directly home and deteriorating within a month is the pattern that makes the department look like an opportunity [7,8].

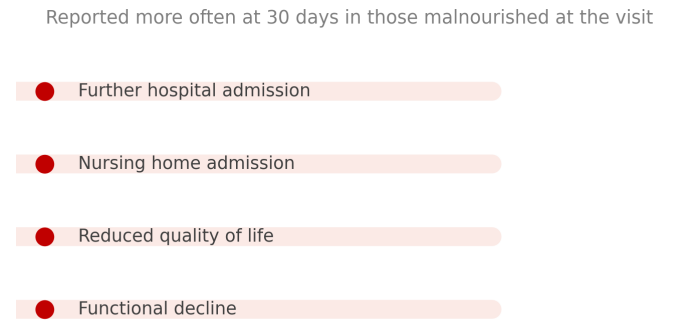


Figure 5: Outcomes at 30 days in those malnourished at the index visit [7]

Measure	Value
Older adults screened	353 [7]
Mean age	79.6 years, SD 7.0 [7]
Women	59.2%, n = 209 [7]
Malnourished	7.6%, n = 27 [7]
At risk of malnutrition	28%, n = 99 [7]

Table 1: The screened cohort as reported [7]

How much the instrument decides: Prevalence in this setting varies widely between studies, and the choice of screening tool is a substantial part of the reason [5,9,10]. A comparison of tools in geriatric emergency department patients found that the NRS-2002, which incorporates acute illness severity into its score, identified nutritional risk in 41.5 per cent and was the only instrument that independently predicted prolonged length of stay [10]. A screening programme therefore does not simply detect a fixed population; it partly defines one (Figure 2) [9,10,11].

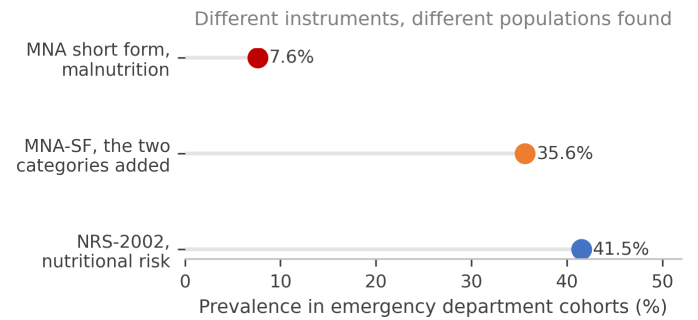


Figure 2: Prevalence reported with different instruments [7,10]

The honest complication: A scoping review of nutrition care for older adults in emergency departments examined 19 studies and found that reported care is largely limited to screening, with comprehensive assessment and intervention often overlooked [5]. There was a lack of evidence that a full nutrition assessment was instigated following a positive screen, and screening was carried out as part of a comprehensive geriatric assessment in only 9 of the 19 studies [5]. Screening is happening. What follows it, mostly, is not [5,6].

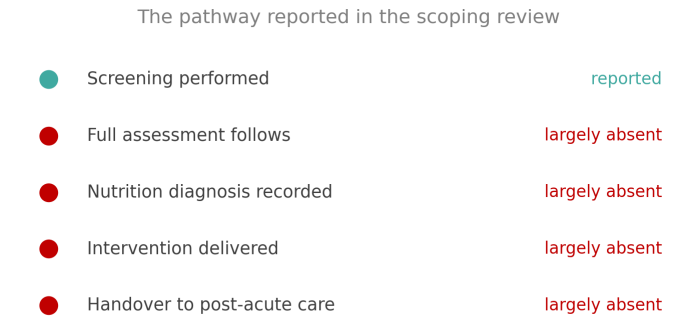


Figure 3: The pathway as reported across 19 studies [5]

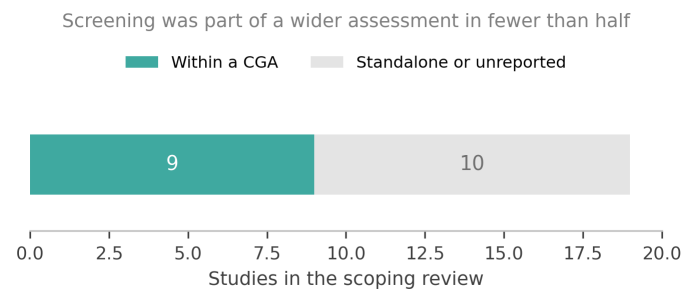
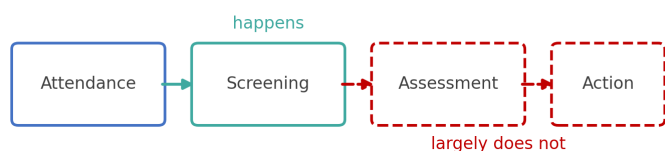


Figure 4: Studies in which screening formed part of a wider assessment [5]

What that reframes: The case for emergency department screening is usually made as though detection were the missing step, and the evidence suggests detection is the step that already occurs (Figure 6) [5,6]. Adding screening to a department that

already screens, without adding the assessment, the recorded diagnosis, the intervention or the handover, produces documentation rather than care [5,6,12]. That is a different problem from the one the phrase neglected window describes, and it has different solutions [6,12,13].

Where the pathway stops



The neglected part of the window is not the screening

Figure 6: Where the pathway stops [5,6]

Step	Status in the reviewed literature
Screening performed	Reported in EDs [5]
Full assessment follows	Little evidence [5]
Diagnosis recorded	Often absent [5,12]
Intervention delivered	Often absent [5]
Handover to post-acute care	Identified as a gap [5,13]

Table 2: What the scoping review found at each step [5]

Why the department is a difficult place to do more: Early decision-making in the emergency department is dominated by acute physiological instability and by the need for rapid disposition, and nutritional vulnerability is under-recognised in that context for reasons of priority rather than ignorance [10,14]. Length of stay is short, dietetic cover is rarely available at the hours older adults attend, and the patient may be discharged before any assessment could be arranged [6,14,15]. A recommendation to assess in the department has to contend with those constraints rather than assert past them [14,15].

Where the evidence for benefit actually sits: Trials of nutrition interventions in this population are concentrated in the period after discharge from acute care rather than within the department itself, and that transition is described as the critical window in the intervention literature [16,17]. Systematic review of those trials reports heterogeneous interventions and outcomes and does not establish a single effective model [16,18]. What the department can plausibly contribute is identification and referral into that period, which is precisely the handover step the scoping review found missing [5,16,17].

Screening tools were not designed for this setting: The instruments in use were validated in community, hospital ward or residential settings, and their performance under emergency department conditions has been examined less [9,11,19]. Acute illness distorts several of the inputs, including recent intake, weight change and mobility, and a tool that incorporates illness

severity will behave differently from one that does not [10,11,19]. Agreement between tools in this population is moderate at best, which is consistent with the prevalence spread rather than an additional finding [9,10,19].

Question	What the literature supports
Is nutritional risk common here?	Yes, over a third [7]
Does it predict poor outcomes?	Yes, at 30 days [7]
Is screening happening?	Yes, widely [5]
Does assessment follow?	Little evidence [5]
Does ED intervention change outcomes?	Not established [16,18]

Table 3: Five questions the phrase neglected window runs together

Frailty and nutrition overlap but are not interchangeable: Frailty screening is more established in emergency departments than nutrition screening, and the two constructs share components including weight loss, weakness and reduced activity [1,3,20]. Where a frailty pathway already exists, adding a nutritional item to it is a more realistic proposition than establishing a parallel process, and the scoping review finding that screening sat within a comprehensive geriatric assessment in fewer than half of studies indicates that integration is the exception [5,20,21]. Whether nutritional screening adds prognostic information beyond frailty and comorbidity burden is a question the tool comparison raised and did not fully resolve [10,20].

Documentation and coding shape what is counted: Whether a nutritional diagnosis is recorded affects both the patient's onward care and the apparent prevalence in routine data, and recorded prevalence is consistently lower than screened prevalence [12,22,23]. This means audits based on coded data will understate the problem in departments that screen but do not record, which is the pattern the scoping review describes [5,12,22]. Improvement measured from coded data alone could therefore reflect documentation practice rather than care [12,22,23].

Which definition of malnutrition is being applied: Consensus criteria published in 2019 separate screening from diagnosis and require a phenotypic and an aetiological criterion for the latter, which is a step the emergency department pathway rarely reaches [5,24]. The instruments in common use here were designed and validated as screening tools rather than diagnostic ones: the MNA short form for identification of nutritional status in older adults, and NRS-2002 as a risk screen built from controlled trial data [25,26]. Treating a positive screen as a diagnosis conflates two steps the criteria deliberately separate [12,24,25,26].

What the geriatric nutrition guidance recommends: Practical guidance for nutrition and hydration in older people recommends screening at every relevant contact with health services followed by assessment and an individualised plan, which describes the full pathway rather than its first step [27]. Reviews of screening

outcomes in community-living older adults reach a related conclusion, that screening without a defined subsequent process has not been shown to change outcomes [28]. Applying formal screening programme criteria to malnutrition detection raises the same requirement for an effective intervention to follow [29].

Method

This is a narrative review of published literature. Sources were assembled by searching the indexed literature for cohort studies, scoping and systematic reviews, and tool comparison studies concerning nutritional screening, assessment and intervention for older adults attending emergency departments, with precedence given to studies reporting both prevalence and what followed a positive screen [5,7].

Findings are reproduced as their authors published them. Where a figure in this review is arithmetic on published values rather than a reported result, that is stated where it appears [7].

No new patient data were collected and no search protocol was registered, so this is not a systematic review. Screening instruments are described as those the studies used and no threshold is recommended for any individual service.

Concluding Remarks

Nutritional risk among older adults in the emergency department is common, is identifiable in the time available, and predicts admission, institutionalisation and functional decline within a month. That much is established and it is a reasonable basis for screening.

The evidence does not support the usual next sentence. Screening already happens in the departments that have been studied. What is missing is assessment after a positive result, a recorded diagnosis, an intervention, and a handover into the post-acute period where the intervention evidence actually sits. A department that screens and does none of those has completed the step that was not the problem.

The practical implication is that the case for emergency department nutrition care should be made for the pathway rather than for the screen, and that a service adding screening without the steps after it should expect to detect more and change nothing.

What a department could reasonably do: The elements the evidence supports are modest and sequential: screen with an instrument suited to acute illness, record the result where the next clinician will see it, and route positive results to a service that exists rather than to one that would have to be created [5,10,12,32]. Where a comprehensive geriatric assessment pathway is already running, attaching nutrition to it is more likely to survive than a parallel process, and the scoping review indicates that attachment is currently the exception [5,21]. None of this requires resolving whether emergency department

screening changes outcomes, which no trial has tested [16,18].

What would settle the question: A trial would randomise departments rather than patients, compare screening alone against screening with a defined referral route, and measure readmission, functional status and nutritional status at three to six months rather than documentation rates [16,18,32]. The intervention literature already sits in the post-discharge period, so such a trial would connect two bodies of evidence that are currently separate rather than generate a new one [16,17]. Its absence is why the case for screening here rests on prevalence and prognosis rather than on effect [7,16,29].

Study Limitations

Prevalence figures come from single-centre cohorts using different instruments and thresholds and are not directly comparable. The scoping review synthesised what studies reported about their own practice, which may understate care delivered but not recorded. Evidence on what follows a positive screen is descriptive rather than comparative.

No trial has randomised an emergency department screening programme and measured downstream outcomes, so the absence of demonstrated benefit from screening in this setting reflects the absence of such trials rather than evidence that screening does not help.

Discharge destination is part of the problem: Older adults discharged directly home from the department, which the Irish cohort found more common among those malnourished, leave without the ward admission that would ordinarily trigger nutritional assessment [7,30]. Nutritional status is associated with readmission within 30 days in this group, so the patients least likely to be assessed are among the most likely to return [30,31]. Any pathway built only around admitted patients will miss them systematically [7,30,31].

Implementation is the studied obstacle: Work on introducing nutrition screening in acute settings identifies competing priorities, unclear ownership and absent downstream referral routes as the recurring barriers, which matches what the scoping review found in practice [5,32]. Economic analyses of malnutrition in acute care estimate substantial costs and are used to argue for screening, though they generally assume that detection is followed by effective treatment, which is the assumption in question [33]. Patients themselves report that nutrition is rarely raised during an emergency attendance and describe being open to it [34].

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The authors thank the reviewers who reported how many studies situated screening within a comprehensive assessment, which is what makes the gap after the screen visible.

The phrase itself is worth examining: Describing the department as a neglected window presupposes that nothing is currently done there, and the evidence indicates that something is: patients are screened [5,7]. What is neglected is the interval immediately afterwards, and locating the neglect correctly matters because the two have different remedies [5,6]. Adding screening capacity addresses a bottleneck that is not where the flow stops [5,32]. Building a referral route addresses one that is [13,16,32].

A comparison worth drawing: Frailty screening entered emergency departments attached to an assessment pathway and a receiving service, and its adoption is consequently further advanced [3,20,21]. Nutrition screening has largely arrived without either, which is a plausible explanation for the pattern the scoping review documented, and it suggests that the sequence of implementation matters as much as the instrument chosen [3,5,21,32]. The lesson is transferable rather than specific to nutrition [20,21,32].

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Measuring the right thing: If a department reports its screening rate as the indicator of nutritional care, it can reach full compliance while nothing downstream changes, which is the situation the scoping review describes across 19 studies [5,12]. The measures that would show whether care improved are the proportion of positive screens receiving an assessment, the proportion referred onward, and the proportion with a recorded plan at discharge, none of which requires new data collection beyond what a functioning pathway would generate anyway [5,12,32]. Choosing the screening rate as the indicator is what makes the gap invisible in service reporting [12,22,23].

Conflict of Interest

The authors declare no competing interests.

Ethics Statement

This article reviews previously published studies only. No new patient data were collected and no participants were recruited, so ethical approval was not required.

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