

HEARD IT THROUGH THE
grapevine



COVID SUPERHERO EDITION • E-NEWSLETTER VOL 7 • SEPT 2020



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hello

FROM THE ADSA PRESIDENT

On Wednesday 25 March 2020, we sent out our first formal COVID-19 communication to members. Now, almost six months later, our lives as healthcare professionals have irrevocably changed. During this time, I am thankful to report that the Association for Dietetics in South Africa stood strong and I would like to share some of the progress made.

STEPPING INTO THE WORLD OF ONLINE WEBINARS

ADSA, as the HPCSA-appointed CPD accreditor, aims to provide CPD points that are accessible to and affordable for all South African nutrition professionals. The Executive Committee had been planning to host online CPD accredited webinars for some time, but the sudden lockdown meant that the planning phase was over, and that implementation had to begin. Under the leadership of Michelle McDermott, our CPD Executive portfolio holder, **17 CPD points were made available during lockdown, of which more than 80% were free.**

The ADSA webinars are
freely available to access
at <https://www.adsa.org.za/webinars>

While online CPD events may lack the positive benefits of a face-to-face event, we have also seen the potential that these online events hold. No longer does the dietitian located in remote areas need to drive hours to attend a branch event and take off full days from work. For such dietitians, the cost of CPD events escalate quickly with high transport cost, loss of daily income, and event registration fees. The nutrition professional can also

listen to their topic of interest even if hosted in another province, country, or continent. These events are also relatively short and can easily be worked in during lunch while you can enjoy your healthy sandwich.

DIVERSIFYING TO BE TRUE TO ADSA'S VISION

ADSA strives to enhance diversity on various levels. Diversity extends beyond gender, race, and ethnicity that we often associate it with but also includes age, religion, cultural background, languages, abilities, location, and so the list continues. Improving diversity increases and broadens a variety of different perspectives, increases creativity, and results in better decision making. Diversity needs to be a key priority if we want to be true to our vision:

“To represent and develop the dietetic profession to contribute towards achieving optimal nutrition for all South Africans.”

In addition to the above, I am proud to say that ADSA released our diversity statement in June 2020. While the grammar, wording, and paraphrasing of such a document are important, even more important is that the values written on paper are embedded in the hearts of ADSA members and carried through in our actions.

STRENGTHENING NETWORKS

During this term, I look back with gratefulness at the progress that has been made. We have broadened our network extensively, cherishing old and trusted stakeholders and also engaging with new ones. Recently, ADSA has engaged with farmers, economists, sleep specialists, and non-government organisations, to name a few, around important nutrition-related topics. **ADSA's campaign during World Breastfeeding Week reached an estimated 39 million people** on various media platforms (radio, television, printed media) and to a diverse range of audiences (e.g. OFM, Kaya FM, Sowetan, Times Live, etc.)

There are other examples of how the nutrition and dietetic fraternity of South Africa stood together during this time. Together with the Nutrition Society of South Africa (NSSA) and Dietetics-Nutrition is a Profession (DIP), the 'Call to Address Malnutrition in The Country' was released under the leadership of Maria van der Merwe, Executive Public Sector Portfolio holder. This collaboration yielded significant results and ADSA would like to thank both the NSSA and DIP for adding their voices to ours.

ADSA and the NSSA also compiled an e-recipe book. The purpose of the booklet is to provide information and recipes that will assist people in using what they may receive in food parcels or procure as more affordable and non-perishable food items to

prepare nutrient-dense meals. The booklet has been distributed to various organisations assisting with food relief.

As we celebrate the victories of the past year, we acknowledge that there is still more to be done. We acknowledge the role of each and every member, branch committee member, branch chair, and executive portfolio holder that has greatly contributed to our success. We thank all dietitians for the

work that you have done during these unprecedented times. We applaud you! We acknowledge every South African dietitian living and working through this pandemic. We extend our thoughts to those dietitians who have been infected while in the line of duty, and we wish you a speedy recovery.

YOURS IN NUTRITION,

Christine Taljaard-Krugell

As we embrace this season of change around the world, ADSA Exec is proud to launch a fresh and exciting new ADSA website and revamped ADSA logo. The essence of the logo has not changed, but it has been modernised and made easier to use in different formats. Explore the new website at:



www.adsa.org.za



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THE superhero DIETITIANS OF COVID-19

The Corona virus pandemic has affected the lives and livelihoods of people around the world. As dietitians, COVID-19 has affected food safety in community dietetics, ICU preparedness in clinical dietetics, virtual consultations in the private sector, lecturing at universities, and much, much more. As a profession, it is humbling and motivating to witness how dietitians have adapted in their various roles and responsibilities in these unprecedented times.



**Dr Heather
Sedibe-Legodi**

HOD AND SENIOR
LECTURER

Department of Human
Nutrition, University of
Pretoria

Within the academic space, COVID-19 has challenged and changed our roles as lecturers. **We now have to teach our dietetics students in the comfort or challenge of their homes. We have to understand the diverse and sometimes challenging circumstances that our**

students learn in. We need to think of how we can maximise technology as a tool to teach and assess students remotely. Competition is increasing with social media for the attention of our students. The sudden pandemic has also pushed us to connect with other training universities to share ideas on how we can train and assess our students remotely/virtually. I believe we are in challenging and yet exciting times; we have more opportunities to train students who will reach more communities through online platforms. Our communication skills are challenged. We have seen our students emerging and creating online



material to promote nutrition education. This approach is showing to be very cost effective and wider reaching. The sustainability of the nutrition interventions that our students create is amazing.



**Christiaan
Greyling**

PRIVATE PRACTICING
DIETITIAN

Welkom, Free State

My sister was born with oesophageal atresia, a rare birth defect where the baby is born without part of the oesophagus. This forced our family to be as healthy as possible, and looking back, this was a blessing in our lives, and I am grateful to have grown up in a health conscious home.

One Wednesday afternoon in July, I spoke to one of the GP's in our small town of Welkom. I was interested to learn that scientists had started training dogs in Europe to pick up on the unique smell of urine and sweat of patients who had been infected with COVID-19. That same morning, I started coughing and by the evening I started having spiking temperatures. The next morning, I tested positive for COVID-19.

I had the expected flu-like symptoms. I lost my sense of smell and foods containing vinegar tasted very strange. Working in a hospital we see the worst of COVID-19 cases, those requiring additional medical support. **The emotional stress was a challenge,**

wondering if I did enough to protect myself and worried about who I had accidentally infected. Yet the biggest challenge for me was the emotional part of not knowing how tomorrow would look. Would I be better or still get worse? When my physician checked on me and I told him about my emotional roller coaster, his response was, "Remember, the devil is not called the accuser for nothing." I really appreciated his take on things.

During my isolation period I wanted to help others, so I wrote an informed and evidence-based article on nutrition in COVID times that I shared with family and friends. I am grateful to God to be healthy and working again.



Caryn Kotze

3RD YEAR DIETETICS
STUDENT

North West University

The adjustment from having interactions with friends, colleagues, and lecturers to going digital with all online learning has been a big challenge. I have to say it has not been the easiest first semester, but **COVID-19 has taught me to be more self-disciplined, self-assured, and a creative thinker as a dietetics student.** Although it is not what I expected this year to be, it is one I am choosing to learn from. What I have learnt is to turn problems into opportunities which will help me grow in character to be the best dietitian in future.



Mpho Putu

**PROJECT MANAGER:
FOOD AND NUTRITION
SECURORDINATION**

*National Department of
Social Development*

I work for the Department of Social Development (DSD) Household Food and Nutrition Programme which provides food and nutrition services to combat the growing challenge of malnutrition and hunger amongst poor and vulnerable communities. The global crisis caused by the COVID-19 outbreak is of unprecedented proportions, and the consequences of both the virus outbreak and the restrictive measures taken by government are being felt country wide. In addition to the risks of further spread of the virus and the overburdened healthcare systems, **the most acute risk is that the global economic recession will rapidly lead to a food crisis of extraordinary magnitude.**

The COVID 19 crisis and the lockdown compounded the food and nutrition security issues that was already of great concern, threatening to impact further the livelihoods of the world's poorest, of whom a majority depend on state. The closure of many Community Nutrition and Development Centres (CNDs) extended and increased vulnerability, leaving the indigent population with less social security nets, putting its members at a greater risk of severe food insecurity. In times of crisis, the most vulnerable people

such as the elderly, sick, children, pregnant and lactating mothers are likely to run out of food, thereby experiencing hunger and - at the extreme - going for days without eating, putting health and wellbeing at risk.

Since the announcement of the COVID-19 lock-down, the DSD has shifted temporarily its food provision from centre based feeding using the existing network of CNDs to food parcels distribution as a short-term relief measure. **Over the past few months more than five million poor and vulnerable people have benefitted from generous food donations made by DSD in partnership with various organisations and individuals.** This intervention has made a great impact in ensuring access to food for the many destitute across the country, it has certainly gone a long way in alleviating the unforeseen devastating impact of the COVID-19 pandemic.

CHALLENGES

- Households are provided a food parcel for five people for a month. However, this does not guarantee nutritious meals at household level.
- The poor and vulnerable, especially children, the elderly, the sick and those who are pregnant, may be eating what is available at home compromising the nutritional value of the food.
- Beneficiaries are missing out on what could be the only nutritious meal

available to them with the closure of many CNDs.

- Food parcels are expensive and cannot be sustained as demands increase.
- As unemployment soars, more people need food assistance.
- Donors give what they can afford not necessarily considering the circumstances in the family.
- Food prices have been going up, increasing food insecurity and vulnerability.

MOVING FORWARD

- The Department is committed to ensuring access to nutritious food for the poor and vulnerable through funding and partnering with Centre-Based Feeding programme, calling on business to support communities, and ensure food prices are affordable. Families are encouraged to use all measures and efforts to put nutritious food on the table, plant their own vegetables, bake bread, cook, and eat healthy food from their home so no one sleeps hungry.
- The perpetual distribution of food parcels to poor and vulnerable individuals and communities is not sustainable and long lasting measures must be put in place to ensure sustainable interventions in addressing the challenges of hunger, poverty, unemployment, and inequality. We call upon our communities to rise up against hunger and poverty by working

together in communities and also partnering with Government and find ways to eradicate high levels of hunger and extreme poverty.

- The effects of the COVID-19 pandemic will continue to haunt South Africa for years to come. We are currently hard at work developing policies and programmes to deal with the challenges of hunger, poverty, unemployment, and inequality. We would like to take this opportunity to implore communities, business, and civil society to continue to partner with the Department to implement the post-COVID-19 measures that we will be dealing with to up-root gender inequality, hunger, and poverty.
- The Department is preparing to open all its Centre-Based Feeding Programmes, which include ECD, Lunch on Clubs, Drop in Centres, CNDs etc. A COVID 19 management training manual is developed and personnel in all the state funded facilities will undergo the training before resuming with food provision.



Ynthe Buyl

**COMMUNITY SERVICE
DIETITIAN**

*Job Shimankana Tabane
Hospital, Rustenburg*

This year has certainly come with its challenges, from the few hundred cases of corona virus to being a part of those thousands that tested positive.

On 24 June 2020, I received the news that a patient I was seeing in the surgical ward tested positive for COVID-19. I had been exposed three days in a row to the patient that week. Exposed healthcare professionals were asked to stay in the ward. The head of infectious control and an occupational health and safety officer categorized those in the ward to high risk or low risk, according to the hospital's protocol. I was classified as high risk and had to self-isolate for 7 days and then test on day 8.

For seven days I isolated in a cottage separate from the main house and waited in suspense. This was difficult mentally to sit behind glass doors unable to go outside, touch family or friends or to simply give them a hug. During these 7 days I had some body aches, nausea, lots of headaches and a definite loss of appetite, yet no respiratory problems. On day 8 I went to get tested at Ampath Laboratory and the next day I received the results: I was positive for COVID-19. I burst into tears at the shock. I immediately phoned my parents, my mom in tears and my dad not really knowing what to think. They tried their best to make me feel better and that is when I decided to trick my mind into thinking that I just have the flu, nothing more nothing less. This helped me through the difficult days, especially when I lost my sense of smell and slight loss of taste, as I knew those were symptoms from the virus which made me think about it even more. Days went by and my symptoms



To watch a short video by a clinical psychologist on practical tips on coping with anxiety as a healthcare professional in a pandemic, go to <https://www.adsa.org.za/covid19>

did not seem to get any worse, except for terrible headaches.

We all know of the physical symptoms to look out for, but sadly the mental symptoms are never mentioned. I knew that I had to continue eating healthy and exercising to stay sane and to keep my body fueled so it could fight. In the restrictions of quarantine, it feels like you are a sick, dirty animal behind a cage. ***Mentally COVID-19 is draining and that is not something people discuss openly.*** This is the part that I want to share the most, because this was the hardest by far, to see my family having to go through this and see me have bad days feeling so useless. You are not contagious through glass or phone calls. Support those you know who are in quarantine as it goes a lot further than what you might think.



Ashleigh Krige
4TH YEAR DIETETICS STUDENT

University of Pretoria

COVID-19 has introduced a very new way for

dietetics students having to meet their practical requirements in our final year. Internship at the hospitals have been very different to previous years. During the lockdown period in which we were supposed to be doing our internship, we had two weeks of online internship. Nothing compares to the practical experience of working in the hospitals and I am very glad that we can finally be working and training again. Our contact hours at the hospital have been shorted and contact with the patients has been very different. ***This pandemic has grown me as a person and as a professional, being able to put behind personal considerations and worries and step into the middle of the chaos and learn my craft.***



Julie Peacock
PRIVATE PRACTISING DIETITIAN

Umhlanga Hospital,
Durban North

When the news broke of a nationwide lockdown, I, like many others, was shocked and I really fumbled at what it meant for my work, my health as a type 1 diabetic, and my income as a PPD. Through April, I persevered with telehealth consultations under the careful guidance shared by ADSA, and fortunately I was set up for this already working from home. The first month really stretched me, in ways I never imagined. Being in private practice for the last 22 years meant I was fortunate to have a very solid patient

base and an established practice. I reached out weekly to all my current patients via email, encouraging and motivating them to keep healthy, maintain a balanced nutrient intake, and keep glucose levels under strict control. I shared recipes, gave insights into ordering online and gave healthy cooking and freezing tips.

During May, I made some Jars of Hope to give out to the local community, feeling helpless at the plight of hunger. It helped to occupy my time with the practice slowing and kept my mind focused on the positive. I also knitted mini-beanies for the preemie babies in some of our government hospitals for the cold winter on the way.

In this time, I was surprised to get a call from a renowned endocrinologist in Umhlanga, inviting me to join his established, busy practice, servicing diabetic and endocrine patients in the greater Durban area. I felt greatly honoured, yet very apprehensive at the same time, as COVID cases were rising and, as a diabetic, I was wary of the outcome of infection. Perhaps the slower pace of my private work at home spurred me on to take up the challenge with diabetes, my passion that I live and work with daily.

In June, I joined the practice, in addition to the private practice at home. It has been so rewarding and I am thoroughly loving the interaction of the clinic staff, specialists, and endocrine health practitioners. The wearing of PPE has

been challenging too and it certainly brings about a whole new way of communicating with patients when wearing a mask and visor at the same time.

COVID-19 has changed the way I relate to patients now, realizing that a caring, empathetic attitude can be carried over ever more effectively, even when our mouths are covered while speaking. It has taught me to listen better and ask more questions, to engage on a more digital level and to reach out to my patients. My practice is stronger than ever and something positive has come out of this pandemic for me. I feel privileged and grateful to have been able to continue working through. This time has reassured me that our profession is ever-changing yet challenging. It has taught me resilience, dedication, and the utmost respect for all our healthcare workers on the frontline. It has taught me so much about the human spirit.



Alta Kloppers

ADSA EXECUTIVE
COMMITTEE MEMBER:
PPD

*Private Practicing
Dietitian, Gauteng*

The ICU units and general wards at the Netcare Union and Clinton hospitals in Alberton are open areas with none or few isolated cubicles. Hence, when entering these units where COVID-19 positive patients are treated, all healthcare providers are required to wear full PPE. At the

beginning, when we were treating few cases, we conducted virtual consultations through phoning nursing staff. As the pandemic developed and patient numbers picked up, we realised that we had to enter the units as nursing staff was just too busy to attend to our calls and implement our prescriptions.

Having to enter COVID units wearing full PPE posed a new challenge. The use of PPE is restricted to one set per dietitian per unit per day. At the Union and Clinton hospitals, there are two dietetic practices, so the implication was that only one dietitian could enter the unit for the day. As two different practices we had to decide how to manage the situation. A decision was taken that we will share the COVID units by rotating on a weekly basis implicating that each practice would see all COVID positive patients for the entire week, irrespective of the referring doctor. Dietitians working in hospitals would be aware of how protective hospital dietitians are of their referring doctors, meaning such decisions require a lot of planning.

Within 24 hours we were treating COVID-19 positive patients as one team. Formal handovers were done on a Sunday evening. These handovers astounded me: being from different practices with different protocols in place we started talking one language (without really communicating with each other). **We started talking the language of caring for our patients**

through practicing the latest evidence for best nutritional practice. We came together as one team, putting differences aside and did what we had to do to care for our patients and stay safe.

I would like to salute Reginald Kekana and his team (Ntsundeni and Abongile)

from Diet Solutions Dietitians, and Inge Bester, Maretha Doubell, Leje Fritz and Marelize Van der Schyf from Alta Kloppers and Associates for your professionalism, consideration, and dedication in this time. This team made me so proud of our profession.

Blast FROM THE *past*



Send your dietetics and nutrition
Blast From the Past pictures
to adsacomms@gmail.com and
be featured in the next ADSA
e-newsletter.



1992

Final Year Dietetics and Home Economics

University of Natal

Submitted by Kerry-Ann Dolloway



1990

Post Grad Diploma in Hospital
Dietetics

University of Pretoria

Submitted by Annemarie de Beer



2004

4th Year

University of the Free State

Submitted by Claire Julsing Strydom

COVID-19 FAQ FOR *dietitians*



CAN DIETITIANS OFFER TELEHEALTH CONSULTATIONS?

According to the COVID-19 outbreak in South Africa: Guidance to Health Practitioners released on the 26 of March 2020 and amended on 3 April 2020, the HPCSA permits the use of Telehealth for managing new and existing patients remotely using virtual platforms, including video and telephonic links, within specific guidelines and provided

such consultations are done in the best clinical interest of patients. This guideline is only valid during the COVID-19 pandemic and the HPCSA will inform practitioners when this guidance will cease to apply.

HOW CAN I PROTECT MYSELF AND MY PATIENTS DURING THE COVID-19 PANDEMIC?

- Members are encouraged to use their professional judgement to assess all

risks and deliver safe care in your places of work.

- Familiarise yourselves with the protective measures recommended by the National Department of Health (NDOH), National Institute for Communicable Diseases (NICD) and the World Health Organization (WHO), including washing your hands frequently with soap and water; social distancing; avoid touching your eyes, nose and mouth; and coughing or sneezing into your flexed elbow or tissue.
- Wherever possible move face-to-face consultations / meetings / interactions into the virtual space as per the guidelines on tele-health from the HPCSA.
- Do not shake hands. Maintain a reasonable distance between you and your patient.
- Follow the guidelines outlined by the National Department of Health that specifically adhere to the use of personal protective equipment (PPE) under specific circumstances. Only wear PPE as indicated so as not to use these resources unnecessarily.
- Consult with your institution for training on the correct use and disposal of PPE. Ensure that you follow the step-by-step process for

don/doff of PPE as per directives.

- Minimise personal effects in the workplace. All personal items should be removed before entering clinical areas and donning PPE. This includes jewellery, cell phones, pagers, stationery, etc.
- If you are required to consult with a client during an emergency, ask your client to inform you immediately if they are diagnosed with COVID-19 and inform your clients and close contacts immediately if you are diagnosed with COVID-19.
- Do not meet with clients if you are experiencing symptoms such as a fever, runny nose, cough, shortness of breath or a sore throat and vice versa.

WHERE CAN I FIND INFORMATION ON THE NUTRITIONAL MANAGEMENT OF PATIENTS WITH COVID-19?

The South African Society for Parenteral and Enteral Nutrition (SASPEN) recently published a statement on the nutritional management of patients with COVID-19. Several international bodies have also published new guidelines. Links to these guidance documents can be found on the COVID-19 page on ADSA's website.



For more COVID-19-related information go to
<https://www.adsa.org.za/covid19>

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FROM THE ACADEMY

Evidence Analysis Center

Malnutrition Care During the COVID-19 Pandemic: Considerations for Registered Dietitian Nutritionists

Deepa Handu, PhD, RDN, LDN; Lisa Moloney, MS, RDN; Mary Rozga, PhD, RDN; Feon W. Cheng, PhD, MPH, RDN, CHTS-CP

ABSTRACT

Recent evidence examining adults infected with coronavirus disease 2019 (COVID-19) has indicated a significant impact of malnutrition on health outcomes. Individuals who have multiple comorbidities, are older adults, or who are malnourished, are at increased risk of being admitted to the intensive care unit and of mortality from COVID-19 infections. Therefore, nutrition care to identify and address malnutrition is critical in treating and preventing further adverse health outcomes from COVID-19 infection. This document provides guidance and practice considerations for registered dietitian nutritionists providing nutrition care for adults with suspected or confirmed COVID-19 infection in the hospital, outpatient, or home care settings. In addition, this document discusses and provides considerations for registered dietitian nutritionists working with individuals at risk of malnutrition secondary to food insecurity during the COVID-19 pandemic.

J Acad Nutr Diet. 2020;■(■):■-■.

MEDICAL NUTRITION THERAPY (MNT) plays an important role in the prevention and treatment of malnutrition. There is significant evidence to demonstrate that protein-energy malnutrition from inadequate dietary intake can increase risk of infectious diseases.¹ Reciprocally, any exposure, including infectious disease, that impairs immune function and causes malabsorption, increased catabolism, or decreased nutrient intake, can increase risk of malnutrition. Exploratory studies indicate that patients infected with coronavirus disease 2019 (COVID-19) experience some or any of the following symptoms: fever, cough, shortness of breath, muscle ache, confusion, headache, sore throat, chest pain, pneumonia, diarrhea, nausea and vomiting, and loss of taste and smell; all of which can influence nutrition status and ultimately immune function.^{2,3} The term *malnutrition* is defined most simply as imbalanced intake of protein and/or energy over prolonged periods of time, and can occur in both undernutrition and overnutrition.⁴ The current

document provides guidance that focused primarily on protein-energy malnutrition, which can result from inadequate intake, increased requirements, impaired absorption, and/or altered nutrient utilization.⁵

The purpose of this document is to provide general guidance and practice considerations for registered dietitian nutritionists (RDNs) providing care to the malnourished adult in the hospital, outpatient, or home care settings during the COVID-19 pandemic, including the following:

- Screening and assessment for malnutrition in adults with suspected or confirmed COVID-19 infection;
- MNT for critical illness in the hospital for adults with suspected or confirmed COVID-19 infection;
- MNT for adults with suspected or confirmed COVID-19 infection managing mild to moderate symptoms at home, including transitioning to home from the hospital; and
- Adults experiencing increased food insecurity secondary to the COVID-19 pandemic.

While there are currently no nutrition guidelines specifically for adults with or at risk for COVID-19 infection,

many existing guidelines from the Evidence Analysis Library and other organizations are still applicable and can be used to provide guidance when working with adults with COVID-19 infection.⁶ However, some adjustments might be required to meet the increased metabolic and functional needs caused by the COVID-19 infection and treatments. The following discussion and guidance are based on best current knowledge and existing guidelines from the Academy of Nutrition and Dietetics (Academy) and other organizations. This document is not exhaustive and there is still much to be learned about the effect of nutrition management on COVID-19 infection and severity.

I. SCREENING AND ASSESSMENT OF MALNUTRITION IN ADULTS WITH SUSPECTED OR CONFIRMED COVID-19 INFECTION

It has been well-established that malnutrition is associated with poor health outcomes.⁷ In the context of an infection such as COVID-19, an individual with malnutrition might have suboptimal immunity, contributing to a longer or more difficult recovery. Nutrition screening aims to identify patients who are at risk for malnutrition

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FROM THE ACADEMY

and provide a referral for an RDN to deliver detailed nutrition care based on the Nutrition Care Process,⁸ including assessment, diagnosis, and intervention by an RDN, in order to treat and prevent further malnutrition and consequent adverse health outcomes.

For adults with suspected or confirmed COVID-19 infection, the Malnutrition Screening Tool can be used to identify individuals who are at risk of malnutrition regardless of setting.

A recent systematic review and corresponding position paper published by the Academy states, “based upon current evidence, the Malnutrition Screening Tool should be used to screen adults for malnutrition (undernutrition) regardless of their age, medical history, or setting.”⁹

The Malnutrition Screening Tool appears to still be applicable for adults with COVID-19, as it is a quick and easy-to-use validated tool based on 2 questions addressing decreased intake due to poor appetite and recent unintentional weight loss.¹⁰ Due to limited resources and staff during the COVID-19 pandemic, some nutrition screening procedures can require flexibility to better meet the safety needs and operational needs of an organization. For example, while nurses or other team members might have conducted nutrition screening before the COVID-19 pandemic, during the pandemic, these professionals might be needed for emergency patient care and not be able to perform malnutrition screening. In these cases, the nutrition team could carry out the screening process so that patients who are at risk for malnutrition can receive appropriate nutrition assessment and intervention without delay. Also, special coordination, such as conducting nutrition screening using patient-room telephones, can be considered to minimize staff exposure.

For adults with suspected or confirmed COVID-19 infection, the RDN should perform a comprehensive nutrition assessment to identify malnutrition regardless of setting.

Although there are currently no nutrition guidelines specifically for patients with COVID-19, the Academy’s assessment recommendations within evidence-based practice guidelines, available from the Evidence Analysis Library, can be used to guide nutrition assessment for individuals with

suspected or confirmed COVID-19.⁶ The **Figure** displays some examples of nutrition assessment guidance for critically ill individuals in the following domains: food and nutrition-related history, anthropometric measurements, biochemical data, medical tests and procedures, nutrition-focused physical findings, and client history. Most of these nutrition assessment tools and procedures are applicable to adults with suspected or confirmed COVID-19 infection. For example, the Subjective Global Assessment can still be used to diagnose nutrition status, and it is important to take medications and intravenous drips, such as propofol or dextrose 5%, into consideration when assessing patients, so nutrition prescription can be adjusted as needed. In the context of the COVID-19 pandemic, touching or gently palpating the patient to determine muscle and fat store losses might not be possible. In these cases, the RDN can still conduct visual inspection to note indentations and bony prominences, which could indicate somatic losses. For RDNs working directly with patients infected with COVID-19, personal protective equipment should be used per institution policy while conducting in-person nutrition assessment. RDNs can also utilize nursing and physician notes to provide evidence of wasting as the disease progresses.

A comprehensive assessment should result in the RDN determining the nutrition diagnosis. Examples of potential nutrition diagnoses applicable to adults infected with COVID-19 can include malnutrition, increased nutrient needs, predicted inadequate energy intake, altered gastrointestinal function, or inadequate energy intake. In addition, nutrition assessment can assist in identifying the key etiology of the diagnosis, which will help the RDN determine the best intervention for each patient. For example, an RDN might identify a patient’s inability to reach protein and energy needs orally, resulting in the need for supplemental oral or enteral nutrition (EN).

II. MNT FOR ADULTS WITH MALNUTRITION IN THE INTENSIVE CARE UNIT WITH SUSPECTED OR CONFIRMED COVID-19 INFECTION

Most patients admitted to the intensive care unit (ICU) with COVID-19 are

acutely malnourished.¹² Poor appetite is common with infection, and patients with noninvasive ventilation (NIV) (ie, no endotracheal tube or tracheostomy tube), such as continuous positive airway pressure or bilevel positive airway pressure, often have inadequate intake of calories and protein to meet needs.¹³ Critically ill patients in the ICU should be provided with small frequent feedings, including high-energy and high-protein foods and oral nutrition supplements. If protein and energy needs cannot be met with oral intake, nutrition support should be initiated. Although EN is typically the preferred route for nutrition support, airway complications can occur in patients with NIV, and parenteral nutrition (PN) can be considered under these conditions.¹⁴

In individuals with suspected or confirmed COVID-19 infection in the ICU who are not mechanically ventilated, RDNs should work with the multidisciplinary team to ensure adequate protein and energy intake. When needs cannot be met orally, EN is preferred to PN. If EN is not appropriate or tolerated, PN must be initiated in a timely manner to treat and prevent further malnutrition.

EN Initiation

In adults with suspected or confirmed COVID-19 infection in the ICU, RDNs should work with the multidisciplinary team to ensure nutrition support is initiated within 36 hours of hospitalization or within 12 hours of intubation.

Nutrition support should be initiated as soon as possible, ideally within 36 hours of hospitalization or within 12 hours of intubation.¹⁵ In adults in the ICU, requiring nutrition support, EN should be provided instead of PN if the patient is hemodynamically stable and has a functional gastrointestinal tract.^{11,14,15} The RDN should consider holding EN if:

- mean arterial pressure <65 mm Hg¹⁵;
- escalating number and doses of vasopressors¹⁵;
- rising lactate levels¹⁵;
- unexplained abdominal pain, nausea, vomiting, diarrhea, or abdominal distention¹⁵; or
- uncontrolled shock, life-threatening hypoxemia, hypercapnia, or acidosis.¹⁴

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FROM THE ACADEMY

CI^a: Assessment for Critically Ill Patients

The registered dietitian nutritionist's (RDN's) assessment of critically ill adults should include, but not be limited to, the following:

Food and Nutrition–Related History:

- History of nutrient intake (eg, energy intake, meal–snack pattern, and macro- and micronutrients)
- Adequacy of nutrient intake/nutrient delivery
- Bioactive substances (eg, alcohol intake, soy protein, psyllium, and fish oil)
- Previous and current diet history, diet orders, exclusions and experience, and cultural and religious preferences
- Changes in appetite or usual intake (as a result of the disease process, treatment, or comorbid conditions)
- Disease-specific nutrient requirements
- Food allergies/intolerances
- Appropriateness of nutrition support therapy for the patient
- Food and nutrient administration (ie, oral, enteral, or parenteral access)
- Physical activity habits and restrictions

Anthropometric Measurements:

- Weight, height
- Weight change
- Body mass index (calculated as kg/m²)
- Body compartment estimates (fat mass, fat-free mass)

Biochemical Data, Medical Tests, and Procedures:

- Biochemical indices (ie, glucose, electrolytes, and others as warranted by clinical condition)
- Implications of diagnostic tests and therapeutic procedures (ie, indirect calorimetry measurements, radiography for confirmation of feeding tube placement, and other gastrointestinal diagnostic tests)

Nutrition-Focused Physical Findings:

- Nutrition-focused physical examination that includes, but is not limited to, fluid assessment, functional status, wound status, clinical signs of malnutrition/overnutrition, and/or nutrient deficiencies
- Intake and output, including stool and fistula output and wound drainage
- Existing or potential access sites for delivery of nutrition support therapy
- Abdominal examination
- Fluid status (ie, edema, ascites, and dehydration)
- Vital signs

Client History:

- Medical and family history and comorbidities
- Surgical intervention
- Effect of clinical status on ingestion, digestion, metabolism, and absorption, and utilization of nutrients
- Indicators of acute or chronic nutrition support–related complications
- Medication management
- Factors that might influence existing or potential access sites for delivery of nutrition support therapy

Assessment of the above factors is needed to correctly diagnose nutrition problems and plan nutrition interventions. Inability to achieve optimal nutrient intake can contribute to poor outcomes.

(continued on next page)

Figure. Nutrition assessment of critically ill adults. ^aCI=critical illness. Adapted from the Academy of Nutrition and Dietetics's Critical Illness guidelines.¹¹

When EN is not feasible or appropriate, PN might be necessary to treat or prevent malnutrition. PN will require management by a multidisciplinary care team due to high risk for line sepsis and metabolic

complications, such as refeeding syndrome and hyperglycemia.

EN Administration

EN should be provided initially via a nasogastric tube or orogastric tube

because placement of feeding tubes in the small bowel could delay initiation of feeding and could increase risk of spreading infection, due to the need for skilled staff and confirmation of feeding tube placement.^{14,15} The height

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Rating: Consensus

Imperative

CI: Reassessment of Critically Ill Adults

The RDN's reassessment of critically ill adults should include:

- Changes in nutrient needs
- A determination of daily actual intake of enteral nutrition (EN), parenteral nutrition (PN), and other nutrient sources
- EN/PN access site
- Changes in clinical status, weight, biochemical data, and intake and output
- Changes in nutrition-focused physical assessment findings.

Rating: Consensus

Imperative

Figure. (continued) Nutrition assessment of critically ill adults. ^aCI=critical illness. Adapted from the Academy of Nutrition and Dietetics's Critical Illness guidelines.¹¹

of the bed should ideally be elevated 30 to 45 degrees,¹¹ and the nasogastric tube size should be a 10 to 12 French, preferably 12 French, to facilitate bolus feeding, if necessary.^{15,16} Enteral feeding for patients in prone position is not contraindicated. However, if possible, the height of the bed should be elevated 10 to 25 degrees.¹⁵

If feeding pumps are available, continuous feeding via a feeding pump is recommended.^{15,17} If feeding pumps are not available, the next alternative is a gravity feed. If a gravity feed is not possible, bolus feedings should be provided.¹⁵ Bolus feeds should not be provided to patients with gastric abnormalities or patients requiring post-pyloric feedings.¹⁶ The RDN should develop the bolus feeding and flushing schedule in accordance with fluid restrictions, institutional policies, and how frequently the nurse enters the patient's room, to minimize staff exposure to infection.

EN Rate and Progression

In adults with suspected or confirmed COVID-19 infection, RDNs should work with the multidisciplinary team to develop an individualized nutrition prescription based on thorough assessment of protein and energy needs to prevent further decline in nutritional status.

Indirect calorimetry is typically recommended as best practice for estimating energy expenditure. However, indirect calorimetry is not recommended during the COVID-19 pandemic because it requires disconnection from the ventilator circuit and a considerable amount of time, both of which increase

risk for COVID-19 transmission to health care providers.¹⁴

RDNs should initiate hypocaloric EN feedings and progress to 15 to 20 kcal/kg actual body weight (ABW) (use ideal body weight if body mass index [BMI; calculated as kg/m²] is >30), or <70% of Penn State Equation Estimate¹¹ within the first week.^{14,15} During the second week, EN should be advanced to 25 kcal/kg ABW; 11 to 14 kcal/kg ABW if BMI is 30 to 50; and 22 to 25 kcal/kg ideal body weight if BMI >50.^{14,17} Practitioners must account for energy intake from drips and medications, such as propofol, when determining energy needs from EN. EN should provide 1.2 to 2.0 g protein/kg ABW in patients with normal weight status, and 1.2 to 2.0 g/kg IBW if BMI >30.^{15,17}

EN Formula and Supplementation

In adults with suspected or confirmed COVID-19 infection, RDNs should take overall nutrition assessment, including nutrient needs, fluid status, and interventions to address fluid status, into consideration when selecting the type of EN formula.

In adults who are critically ill in the ICU, fluid management is impacted by a multitude of factors, including COVID-19 infection pathology. For the initial resuscitation of patients with COVID-19, physicians are frequently restricting fluid volumes.¹⁸ To further complicate assessment of fluid status, approximately 40% of patients who are critically ill with COVID-19 infection are developing acute kidney injury.¹⁹ The exact cause of acute kidney injury in these patients is unknown; however, dehydration starting before admission could be a contributing factor.

Patients who are critically ill with COVID-19 infection could potentially be receiving a significant amount of energy from drips and medications and, due to high protein needs, RDNs should select high-protein formulas (≥20% protein) during the acute phase of the illness.¹⁵ RDNs should evaluate blood urea nitrogen and creatinine trends as part of their nutrition assessment and adjust the EN rate and formula as appropriate. Immune-modulating formulas are another option because, theoretically, they can alter a patient's immune response and clinical outcomes. Unfortunately, consistent high-quality evidence for immune-modulating formulas are lacking and, therefore, cannot be formally recommended at this time for patients with COVID-19 infections.^{11,15}

Some patients might need additional protein and fiber beyond what is provided in the formula. Once patients are no longer in the acute phase of COVID-19 illness, supplemental protein and fiber should be considered. To reduce staff exposure, supplemental protein and fiber should be provided together, along with appropriate flushes.¹⁵ Some patients recovering from COVID-19 infection begin to experience diarrhea, at which point a high-fiber formula should be considered.

EN Considerations for NIV

In patients with NIV, feeding tube placement might be contraindicated due to potential issues, such as air leakage, distention of the stomach, or if the patient is in the prone position.¹³ Stomach distention can lead to poor feeding tolerance and impaired diaphragmatic function. If nasogastric/

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orogastric tube placement is appropriate, feeding pumps should be prioritized to patients on NIV so they can be fed continuously. If a feeding pump is not available, a gravity drip should be considered. Bolus feeds should not be used in patients with NIV due to increased risk for aspiration.¹³

Monitoring and Evaluation

In adults with suspected or confirmed COVID-19 infection, RDNs should monitor nutrition support tolerance daily and work with the multidisciplinary team to promote tolerance.

Tolerance can be evaluated through a physical examination, including abdominal distention, diarrhea, and laboratory values. Gastric residual volume (GRV) should not be used as the sole indicator of EN tolerance. Practitioners should recommend against holding EN when GRV is <500 mL in the absence of other signs of intolerance.^{11,15,20} To promote EN tolerance, the RDN should work with the multidisciplinary team to promote the following initiatives:

- Patients beds should be upright at an angle of 30 to 45 degrees (10–25 degrees if prone).
- If GRVs between 200 and 500 mL, consider promotility agents.
- If the abdomen remains distended after the above initiatives, consider aspirating the stomach and checking GRV; GRV <500 mL/6 h is considered acceptable, repeat after 6 hours if GRV is >500 mL.¹¹
- In the event a patient is experiencing diarrhea, soluble fiber supplementation should be provided.^{11,15}
- If the patient is still not tolerating EN, consider placement of nasogastric tube.¹⁵
- If EN is not feasible, PN should be initiated as soon as possible.

In addition to physical assessment, laboratory values should be monitored daily. RDNs should monitor for refeeding syndrome and hyperglycemia, especially among patients receiving PN.

To monitor for refeeding syndrome, RDNs should monitor sodium and fluid balance and serum phosphorus, potassium, magnesium, and calcium, which can decrease rapidly.²¹ If refeeding syndrome is suspected, electrolytes

should be replaced immediately intravenously and feeding rate should be decreased.²¹

Post Intubation

Prolonged ICU stay can exacerbate muscle catabolism and therefore increase protein needs.¹⁴ Furthermore, dysphagia can result from post-intubation trauma, and its presence for a prolonged period can lead to consequences such as aspiration pneumonia and malnutrition.²² The nutrition care plan for these patients should incorporate recommendations from the speech-language pathologist and should accommodate increased nutrient requirements of the patients, food preferences, and availability of resources. If severe dysphagia persists and energy and protein needs cannot be met, the RDN might need to either initiate or resume EN. If EN is not possible, PN should be provided until oral or EN can be resumed.¹⁴

III. MNT FOR MALNUTRITION IN ADULTS WITH SUSPECTED OR CONFIRMED COVID-19 INFECTION IN OUTPATIENT AND HOME-CARE SETTINGS, INCLUDING TRANSITIONING TO HOME FROM THE HOSPITAL

According to studies from China and case reports in the United States, the majority of all COVID-19 patients exhibited mild to moderate symptoms and managed their illness at home.^{3,23} Common symptoms of COVID-19 can lead to problems with nutrient absorption and/or overall inadequate dietary intake. Patients recovering from COVID-19 infection who are discharged from the hospital might still be experiencing COVID-19 symptoms and might be malnourished and therefore have increased nutrient needs. For individuals managing or recovering from COVID-19 symptoms in their homes, maintaining adequate nutrient intake and hydration is critical.

In adults with suspected or confirmed COVID-19 infection who are managing their illness at home, it is crucial for RDNs to provide remote MNT in order to help achieve or maintain optimal nutrition status. In adults with suspected or confirmed COVID-19 infection who

are managing their illness at home, RDNs should work with patients and their families to ensure adequate intake of energy, protein, and hydration.

When counseling patients with suspected or confirmed COVID-19 infections who are in their homes or in the outpatient setting, RDNs can advise patients and their families of the following:

- Ensure adequate intake of energy and protein by meeting, at minimum, 100% of the recommended dietary allowance for energy and protein based on age and sex. These requirements will likely be increased due to the pathology of COVID-19 infection.
- High-calorie, high-protein meals and snacks can help prevent weight loss and maintain lean muscle mass. For example, RDNs can advise eating vegetables with cream, butter, margarine, cheese sauce, olive oil, or salad dressing to increase energy intake and choosing foods high in protein, such as milk, eggs, cheese, meats, fish, poultry, nuts, and beans.²⁴
- Nutrient-dense foods and beverages, including oral nutritional supplements, are good methods to increase calorie and protein intake if oral dietary intake is not adequate to meet needs (eg, protein powders and meal-replacement shakes and bars).²⁴
- For individuals having difficulty coordinating chewing and breathing, beverages might be a better option to efficiently increase energy intake compared to solid foods.
- Micronutrient supplements can help compensate for inadequate oral intake to address deficiencies.²⁴
- Manage nausea, vomiting, and shortness of breath by offering small, frequent meals and snacks.^{25,26}
- Focus on providing foods that require little handling, preparation, or effort to eat.
- Ensure adequate intake of fluids to stay hydrated throughout the day and evening. If the patient is experiencing vomiting and

diarrhea, advise consumption of rehydration drinks.

Additional guidance on managing malnutrition through adequate intake of calories, protein, and hydration can be found in the Academy's Nutrition Care Manual, Evidence Analysis Library, and Malnutrition Quality Improvement Toolkit.^{6,25,27} In addition to nutrition management, RDNs should consider discussing guidelines for managing safe home care practices, including food safety, with patients and their families.^{28,29}

IV. ADDITIONAL NUTRITION CONSIDERATIONS FOR MALNUTRITION IN ADULTS DURING THE COVID-19 PANDEMIC

Adults with Comorbidities

While there is no clear evidence demonstrating a causal relationship between COVID-19 infection and underlying comorbidities, recent evidence suggests that the majority of severe symptoms and complications from COVID-19 infection are reported among older adults and individuals with underlying comorbidities, such as diabetes, chronic kidney disease, cardiovascular disease, or pulmonary disorders.²³ Individuals with these comorbidities are already at increased risk of malnutrition, which can contribute to an impaired immune system and exacerbation of symptoms. It is imperative that individuals with pre-existing conditions, such as chronic kidney disease, cardiovascular disease, hypertension, or pulmonary disorders, receive regular nutrition assessment, and that individuals at moderate or high risk of malnutrition receive effective nutrition interventions by RDNs. RDNs should ensure that individuals with comorbidities have adequate oral dietary intake to meet calorie and protein needs, and oral nutritional supplements can be considered to meet needs if dietary intake is inadequate. The COVID-19 pandemic requires that prevention and management of malnutrition become a focus in patient care.

The Academy has recent guidelines containing recommendations on malnutrition management in chronic kidney disease, cystic fibrosis, and chronic obstructive pulmonary disease.^{6,30,31} These guidelines are still

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relevant to patients with COVID-19 and these conditions; however, implementation of these recommendations should include consideration of COVID-19 pathology, personal protective equipment standards set by Centers for Diseases Control and Prevention,²⁹ and institutional guidelines.

For adults with existing comorbidities and not infected with COVID-19, RDNs should continue to advise consuming a nutrient-dense eating pattern to meet protein and energy needs, with oral supplementation when necessary, to prevent and treat malnutrition.

For adults with existing comorbidities and with suspected or confirmed COVID-19 infection, RDNs should proactively prevent and treat protein-energy wasting by regularly assessing weight and nutritional status when possible, and advising adequate protein and energy intake through diet, with supplementation through oral, EN, or PN, when necessary.

Micronutrients

Among patients at risk or with suspected or confirmed COVID-19 infection, there is a paucity of evidence indicating effects of adding micronutrients through supplementation or intravenously on the risk or severity of COVID infection. Therefore, it is critical for RDNs to rely on their scientific training and clinical expertise to determine whether the patient is deficient in a specific micronutrient and whether treating the respective deficiency is a priority. Existing evidence from a critical illness population can also help inform practice for patients with COVID-19 infections.

V. MALNUTRITION AND FOOD INSECURITY DURING THE COVID-19 PANDEMIC

While COVID-19 infection itself can increase risk for malnutrition, food insecurity caused by the economic crisis and social isolation secondary to the COVID-19 pandemic can also increase risk for malnutrition.³² In 2018, 37 million individuals in the United States were food insecure.³² Adults with food insecurity are at higher risk of chronic conditions, such as mental health problems and depression, diabetes, hypertension, and sleep

problems. Children with food insecurity are at increased risk for poor health, asthma, obesity, anemia, developmental problems, behavioral problems, and aggression and anxiety.^{33,34}

Currently, there have been no major food shortages reported in the United States related to the COVID-19 pandemic.³⁵ However, unemployment rates have soared,³⁶ causing unprecedented demand for unemployment benefits and several initiatives to reduce the burden of monthly payments for rent, utilities, and home or student loans. Despite these measures, many individuals are struggling economically, which can decrease accessibility of fresh and healthy foods. Social isolation measures implemented to prevent the spread of COVID-19 infection can also increase risk for food insecurity. For example, in the United States, 29.7 million children³⁷ depend on free lunches from the National School Breakfast and Lunch Programs, but during the current COVID-19 pandemic, many schools have closed, and clients might be uncertain how to access free meals being provided by schools. Uncertainty of how to access food-assistance programs can increase the daily financial burden on low-income families to provide healthy meals. In addition, individuals who are at high risk of severe symptoms and mortality from COVID-19 infection, including individuals who are elderly, might be wary of shopping at the grocery store or might want to avoid public transportation to the grocery store. RDNs working in the community, outpatient, and hospital settings have a crucial responsibility to identify clients' food access needs and provide federal, state, and local resources to help address these needs.

When appropriate, RDNs should screen for food insecurity, provide guidance and resources for eating healthfully on a budget, and provide resources to improve access to healthy foods.

When working with individuals with or at risk of malnutrition due to food insecurity during the COVID-19 pandemic, RDNs should consider the following:

- It might be advantageous to screen for food insecurity. Validated tools include the 2-item

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Hunger Vital Sign tool, as well as the screening tool from the US Department of Agriculture (USDA).³⁸⁻⁴⁰

- RDNs can counsel individuals and their families to focus on healthful food choices by providing thrifty meal options with grocery lists and recipes. RDNs can also encourage families to reduce their grocery bills by brainstorming methods to decrease food waste.⁴¹⁻⁴⁴
- If possible, RDNs might be able to consult with clients directly in their homes via telehealth. Remote sessions can be an opportunity to reach clients when they are near their cupboards and refrigerators, which can be an effective method of collaborating on dietary changes in real time and place. The Academy offers resources to provide nutrition resources via telehealth during the COVID-19 pandemic.⁴⁵⁻⁴⁸ RDNs should ask clients which communication methods they prefer.
- RDNs can facilitate connecting individuals with grocery delivery services, as well as neighbors, family, and friends to help those infected with COVID-19 get the food they need to prevent and treat malnutrition.

For clients and families at risk for food insecurity, RDNs should discuss options to improve food access through federal, state, and local programs.

Due to the unprecedented economic crisis caused by the COVID-19 pandemic, several federal, state, and local food-assistance programs have developed, enhanced, or modified services in order to meet needs. RDNs should assist in connecting clients with available resources.

- When appropriate, refer clients to a local food bank⁴⁹ or assist them in navigating enrollment in federal food-assistance programs or Meals on Wheels.⁵⁰
- The USDA has provided several “flexibilities and contingencies” for food-assistance programs, including the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women Infants

and Children (WIC), and the National School Lunch and Breakfast Programs, in order to adapt to increased need for these services, along with the reduced capabilities of delivering these services directly to clients.⁵¹

- The USDA’s Food and Nutrition Service responded to the COVID-19 pandemic through efforts to provide school lunches to eligible children when schools are closed through the Summer Food Service Program or Seamless Summer Option,⁵² and RDNs can utilize these tools to assist connecting families with the school lunch program.⁵³
- The USDA has also provided waivers for WIC requirements to accommodate remote services; WIC food substitution waivers; and provision of emergency food allotments to SNAP households.⁵¹

As leaders in nutrition, RDNs should advocate for increased access to healthy foods by supporting state and federal initiatives for increased and emergency food assistance.

Increased risk of food insecurity during the COVID-19 pandemic requires proactive, broad-scale action to help individuals and families improve or maintain nutrition status, preventing even more damage to health from the COVID-19 pandemic. RDNs can affect change on a state and local level via advocacy through the following venues:

- The Academy’s “Action Center” provides templates for letters to representatives or senators to communicate support or opposition for bills that impact public health. RDNs can “take action” by visiting this resource and sending a letter of support to their respective lawmakers to help Americans keep food on the table during the COVID-19 pandemic and to urge congress to prioritize federal food-assistance program funding.⁵⁴
- Monitor the Academy’s Action Center to increase awareness and advocacy for food-assistance programs as opportunities arise.⁵⁴

- “Take action” and monitor opportunities to support food assistance at the Food Research & Action Center⁵⁵ and the Alliance to End Hunger.⁵⁶
- Monitor and utilize advocacy tools provided by the Food Research & Action Center, including to maximize the role of the WIC program to support health and food security.⁵⁷

The COVID-19 pandemic has created an unprecedented need for RDNs to assess and address food insecurity among clients and their families through innovative and conscientious nutrition counseling, referral to and participation in food-assistance programs, and by taking action to advocate for greater access to food assistance on state and federal levels.

VI. RESEARCH NEEDS

In order to inform evidence-based nutrition and dietetics practice for individuals infected with COVID-19, the Academy is seeking to gather data from RDNs who are currently working with patients infected with COVID-19 or whose work has been impacted by the pandemic. In order to inform evidence-based practice, the Academy is seeking to collect patient-level data, as well as data at a systems or process level, using surveillance surveys. The Academy is requesting RDNs register with the Academy of Nutrition and Dietetics Health Informatics Infrastructure (www.ANDHII.org), which is the Academy’s, free, de-identified system for collecting patient-level data, in order to document nutrition care of patients infected with COVID-19. For the patient-level data, the Academy does not specify what, when, or how much data RDNs enter into the Academy of Nutrition and Dietetics Health Informatics Infrastructure system, but requests that practitioners enter data as they have the time and capacity to do so. Collection of this type of patient-level data is needed in order elucidate effective interventions to support RDNs in their day-to-day efforts with COVID-19 patients and for future pandemics.

CONCLUSIONS

MNT is an integral aspect of managing malnutrition due to COVID-19 infection. RDNs should proactively implement appropriate nutrition care plans

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to assess, prevent, and treat malnutrition in collaboration with a multidisciplinary team for individuals with, or at risk for, COVID-19 infection. The guidance provided in this document can assist RDNs in screening, assessing, and intervening to prevent and treat malnutrition in patients infected with COVID-19 who are hospitalized or in an outpatient or home care setting and for those at risk for food insecurity secondary to the COVID-19 pandemic. RDNs should work proactively with multidisciplinary teams and advocate for appropriate and timely nutrition support to effectively improve clinical outcomes and reduce or prevent the adverse consequences of malnutrition in individuals with, or at risk for, COVID-19 infection.

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