Patient Label

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date: Time:	**Actual Admission**	**Patient Reported**	**Any unplanned weight loss in last six months?**
Height	_____ cm	_____ cm	Yes ☐ No ☐
Weight	_____ kg	_____ kg	How much _____kg
		Unable to recall ☐	Previous weight in last six months _____kg
Obtain accurate height/weight and rescreen as soon as possible. If unable to obtain height/weight – check previous patient record (Clinical Portal/TrakCare) and/or consider alternative measurements i.e ulna length (see chart MI 220398)			Source: Patient ☐ Trak/Portal ☐

Date								
Time								
Ward								
Oedema/ Ascites present Y/N								
Scales Used ST = Standing UW = Unable to weigh. Record CH = Chair reason and document HT = Hoist assessment of risk in notes.								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 (current weight from 5-10% = 1 highest weight recorded >10% = 2 in last six months)								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, nutritional intake for > 5 days..... Score 2 Not applicable..... Score 0								
Step 4 Overall Risk of Malnutrition **TOTAL**								
Rescreen on:								
Signature								

Step 5 Management Guidelines	
Overall Risk of Malnutrition	Ensure care plan updated with nutritional requirements, MUST score and actions to be taken to meet patient's nutritional needs.
0	**LOW RISK** - Repeat screening every 7 days
1 or Greater	**MEDIUM/HIGH RISK** - Follow the flowchart for MUST 1 or Greater overleaf
2 or Greater - nil by mouth	**HIGH RISK** - Follow the flowchart for MUST 2 or Greater - nil by mouth overleaf

STEP 5 Management Guidelines

MUST 1 OR Greater

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - » Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - » Offer full cream milk with and between meals.
  - » Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- **Complete a food and drink recording chart,** including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with **'food first'** approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen

NO

Complete the Above Steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to **dietetics** via Trakcare.

MUST 2 OR Greater - Nil by Mouth

- Refer to Speech and Language Therapy according to STOPSS pathway.
- Consider passing NG tube and commencing NG starter regime where clinically indicated (medical and patient agreement is required)
- Refer to Dietetics.

N.B Not all NBM patients will require referral to Dietetics/SLT such as those at end of life or those undergoing procedures requiring NBM.

Some patients who are long term NBM with alternative feeding in place should be discussed with local Dietitians and Nutrition Nurse teams.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission. *also available in Easy Read Version.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/