MUST STEP 5 Management Guidelines

MUST 1

- 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 Nutrition 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 patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording 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

MUST 2 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

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.

NO

Complete the above steps

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.

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

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