



# MALNUTRITION UNIVERSAL SCREENING TOOL

## MUST Step 5: Nutritional Management Plan for Residential and Care Home staff

Completion of this form and insertion in your resident's care plan will provide evidence that you are managing their nutritional risk. It is designed for qualified staff to identify the risk factors, take suitable action if appropriate, and review progress, the following link can help with completion [Nutrition In Care Homes - NHSGGC](#)

10 digit CHI (or DOB):	NAME:	DATE:												
CARE HOME:	EMAIL:	MUST COMPLETED BY:												
MANAGER:	TEL NO:	MUST SCORE:												
HEIGHT: (mtrs)	TODAYS WEIGHT: (kgs)	HIGHEST WEIGHT OVER THE PAST 6 MONTHS (kgs):												
<i>Please ensure you take into account whether your resident has any visible oedema or ascites as this will affect weight recordings. Correcting a resident's weight by using this table will allow a more accurate guide to current BMI as well as percentage weight loss</i>		<b>Guide for assessing average weight of:</b> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <thead> <tr> <th></th> <th>MINIMAL</th> <th>MODERATE</th> <th>SEVERE</th> </tr> </thead> <tbody> <tr> <td>Ascites</td> <td>2.2 kg</td> <td>6.0 kg</td> <td>14.0 kg</td> </tr> <tr> <td>Oedema</td> <td>1.0 kg</td> <td>5.0 kg</td> <td>10.0 kg</td> </tr> </tbody> </table>		MINIMAL	MODERATE	SEVERE	Ascites	2.2 kg	6.0 kg	14.0 kg	Oedema	1.0 kg	5.0 kg	10.0 kg
	MINIMAL	MODERATE	SEVERE											
Ascites	2.2 kg	6.0 kg	14.0 kg											
Oedema	1.0 kg	5.0 kg	10.0 kg											
BMI:  (see calculator below if you need help calculating BMI)	% OF WEIGHT LOSS:  (see calculator below if you need help with this calculation)													
<b>BMI calculator</b>   bmi calculator.xls	<b>% Weight Loss Calculator</b>   weight loss calculator.xls													

## MUST SCORE CALCULATION

### STEP 1 – BMI SCORE

PLEASE SELECT MUST SCORE FOR THE BMI CALCULATION ABOVE

BMI IS <u>ABOVE</u> 20 <input type="checkbox"/> SCORE 0	BMI IS <u>BETWEEN</u> 18.5 & 20 <input type="checkbox"/> SCORE 1	BMI IS <u>LESS</u> THAN 18.5 <input type="checkbox"/> SCORE 2
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### STEP 2 – UNPLANNED WEIGHT LOSS SCORE

PLEASE SELECT MUST SCORE FOR THE % WEIGHT LOSS CALCULATION ABOVE

LESS THAN 5% <input type="checkbox"/> SCORE 0	5 – 10% WEIGHT LOSS <input type="checkbox"/> SCORE 1	MORE THAN 10% <input type="checkbox"/> SCORE 2
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### STEP 3 – ACUTE DISEASE SCORE

PLEASE ADVISE ON YOUR RESIDENTS CURRENT NUTRITIONAL STATUS

IS YOUR RESIDENT ACUTELY ILL <u>AND</u> HAS HAD NO OR IS LIKELY TO HAVE NO NUTRITIONAL INTAKE FOR <u>MORE</u> THAN 5 DAYS	YES <input type="checkbox"/> SCORE 2 NO <input type="checkbox"/> SCORE 0
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### STEP 4 – CALCULATE OVERALL RISK OF MALNUTRITION

ADD MUST SCORES ABOVE TO CALCULATE THE OVERALL RISK OF MALNUTRITION

STEP 1 MUST SCORE:	STEP 2 MUST SCORE:	STEP 3 MUST SCORE:
<b>TOTAL MUST SCORE =</b>		

### STEP 5 – IMPLEMENT NUTRITIONAL ACTION

SELECT MUST SCORE CALCULATION

<input type="checkbox"/> SCORE 0 <b>LOW RISK</b>	<input type="checkbox"/> SCORE 1 <b>MEDIUM RISK</b>	<input type="checkbox"/> SCORE 2 (or more) <b>HIGH RISK</b>
Continue with routine clinical care and <u>repeat</u> screening on a monthly basis	Commence MUST Step 5 documentation	Commence MUST Step 5 documentation

## MUST STEP 5 DOCUMENTATION

10 digit CHI (or DOB):	NAME:	DATE COMMENCED: COMPLETED BY:
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**COMMENCE FOOD & FLUID CHARTS FOR ASSESSMENT & TO ASSIST YOU WITH THE COMPLETION OF ACTION 1 BELOW, IF THE RESIDENT IS NEW TO YOUR HOME PLEASE ENSURE YOU HAVE AT LEAST 3 DAYS INTAKE BEFORE COMPLETING THIS FORM – YOU SHOULD CONTINUE FOOD & FLUID CHARTS WHILST YOUR RESIDENT IS ON MUST STEP 5 TO HELP REVIEW THE NUTRITIONAL AIMS YOU WILL ESTABLISH IN ACTION 2.**

**REMEMBER TO WEIGH WEEKLY**

### ACTION 1 – PROBLEMS AFFECTING NUTRITIONAL STATUS

INDICATE ANY FACTORS AFFECTING YOUR RESIDENT'S ABILITY TO EAT OR DRINK			
		DETAIL ANY ACTION TAKEN	Signature & Date
<b>SWALLOWING DIFFICULTIES</b> <i>Consider referral to Speech and Language Therapy</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>DENTAL PROBLEMS</b> <i>Encourage improved oral hygiene, consider referral to Community Dentist</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>POSTURAL PROBLEMS REQUIRES SUPPORT TO EAT &amp; DRINK</b> <i>Ensure easy food / fluid, consider finger foods using small eating &amp; drinking aids, consider referral to Community Physiotherapist and / or Occupational Therapist</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>RECENT ACUTE MEDICAL ISSUES</b> <i>Could include infection (urine/chest) vomiting and / or diarrhoea, constipation, fracture / falls, pressure sores, oedema or nausea, all of which could have resulted in a recent hospital admission, liaise with GP &amp; review medications.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>MENTAL HEALTH ISSUES OR CHALLENGING BEHAVIOUR</b> <i>Liaise with GP and review, consider referral to Community Psychiatric Nurse (CPN).</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		

**Following completion of Step 1 above, consider if disease progression is recognised as this may indicate that it is not appropriate to commence with MUST Step 5, this should be discussed with the GP (see guidance notes)**

Further nutritional intervention no longer appropriate  Signed:..... Date:.....  
 Further nutritional intervention is still required  Continue to Action 2

### ACTION 2 – ESTABLISH NUTRITIONAL AIMS

TICK AIMS BELOW THAT ARE APPROPRIATE FOR YOUR RESIDENT review these aims using the progress chart below			
		Name and Signature	Date
*Please select only one of these aims			
*AIM 1 - Promote weight gain back to health BMI range	<input type="checkbox"/>		
*AIM 2 - Maintain current weight or nutritional status	<input type="checkbox"/>		
AIM 3 - Optimise nutrient intake during a period of illness	<input type="checkbox"/>		
AIM 4 - Increase and promote adequate fluid intake	<input type="checkbox"/>		

## ACTION 3 – COMMENCE FOOD FORTIFICATION

<b>COMMENCE FOOD FORTIFICATION FOR 4 WEEKS &amp; RECORD ON YOUR RESIDENTS FOOD &amp; FLUID CHARTS</b>			
DAILY INTERVENTION	ENERGY CONTENT (kcal)	PROTEIN (grams)	IMPLEMENTED DAILY
<b>Fortified milk</b> <i>Add 3-4 tablespoons of dried milk powder to 1 pint of milk, use in drinks, cereal, smoothies etc.</i>	560 - 590 kcal per pint	34 -37g	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Extra butter and mayonnaise</b> <i>Add to potatoes, vegetables, sandwiches, biscuits at meals &amp; snacks</i>	75 kcal per portion	n/a	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Single / double cream (50-60mls)</b> <i>Add to soups and puddings</i>	95 - 248 kcal	n/a	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Sugar, jam and honey</b> <i>Add to drinks &amp; puddings throughout the day</i>	20 - 40 kcal per teaspoon	n/a	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Snacks</b> <i>Offer 3 energy dense snacks a day (see snack list)</i>	Aim for a minimum of 150 kcal <b>per snack</b>	6g per snack	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Protein</b> <i>High protein items should be encouraged from menu</i>	Will vary	18-24g per meal	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Milkshakes and supplements</b> <i>Offer homemade milkshakes or over the counter supplements</i>	200 – 550 kcal per drink	8-20g per drink	YES <input type="checkbox"/> NO <input type="checkbox"/>

Ensure all dietary needs, including physical and environmental, are being met and that alternative options are available if required e.g. texture modified snacks, finger foods, etc. Also ensure all food and fluid offered reflects your resident's recorded likes and dislikes, use the dietary notification form if available.

### REMEMBER

- Aim for 3 energy dense meals **every** day
- Aim for 3 nourishing snacks totalling at least 500kcal every day
- Implement a minimum of 3 to 4 of the daily interventions you have identified above
- Inform your chef and kitchen of interventions and your resident's current dietary requirements

### 4 WEEK PROGRESS CHART

NUTRITIONAL AIMS AND PROGRESS AT 4 WEEKS		
Aim(s) <b>fully</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/> Aim(s) <b>partially</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/> Aims(s) <b>not</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/>  Date: Name:	Please explain the reason for the Aim(s) selection:	Please provide information on any action taken:
<b>IF AIMS HAVE <u>NOT</u> BEEN MET AT THE 4 WEEK REVIEW, YOU SHOULD CONTACT YOUR RELEVANT HEALTH CARE PROFESSIONAL (HCP) normally your Care Home Liaison Nurse (CHLN) or Community Dietitian (RD)</b>		
DETAILS OF HCP CONTACTED:	HCP RECOMMENDATIONS:	Date: Name:

### 8 WEEK PROGRESS CHART

NUTRITIONAL AIMS AND PROGRESS AT 8 WEEKS		
Aim(s) <b>fully</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/> Aim(s) <b>partially</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/> Aims(s) <b>not</b> met    YES <input type="checkbox"/> NO <input type="checkbox"/>  Date: Name:	Please explain the reason for the Aim(s) selection:	Please provide information on any action taken:
<b>IF AIMS ARE <u>STILL NOT</u> MET AT THE 8 WEEK REVIEW FOLLOWING THE ABOVE HCP RECOMMENDATIONS, DISCUSS WITH THE HCP AND REFER TO THE COMMUNITY DIETITIAN (if not already involved).</b>		

