MUST

Malnutrition Universal Screening Tool **Refer to full guidance prior to undertaking MUST Screening**	Name DOB Unit no. / CHI	Addressogram, or NHS Lothian

Full MUST guidance is recommended when carrying out the Malnutrition Screening Tool to ensure accurate results and full guidance following outcome of result. Within the Action Plan, please document plan of care   Screening should be carried out weekly or if clinical concerns

Previous refer to Dietician Yes No Please state:	Current Care of Dietician Yes No Community / Other
Usual weight kg (prior to admission)	Height

Guidance

Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**
>20 = 0 18.5-20 = 1 <18.5 = 2 BMI score 0,1 or 2	Unplanned weight loss In past 3-6 months **5% = 0** 5-10% =1 >10% = 2 Weight loss 0,1 or 2	If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days Acute disease 0 or 2	MUST score add steps 1 + 2 + 3	Category Low = 0 Medium = 1 ref to guidance High **≥2** Ref to Dietician

Low Risk 0 **Routine clinical care** Repeat screening weekly	**Medium Risk 1** **Observe** • Document dietary intake for 3days: If improved or adequate intake little clinical concern; if no improvement and clinical concern – follow local policy (snack list available) • Repeat screening weekly	**High Risk 2 or more** • Refer to dietitian • Improve and increase overall nutritional intake (refer to local policy /snack list) • Monitor and review care plan Weekly Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

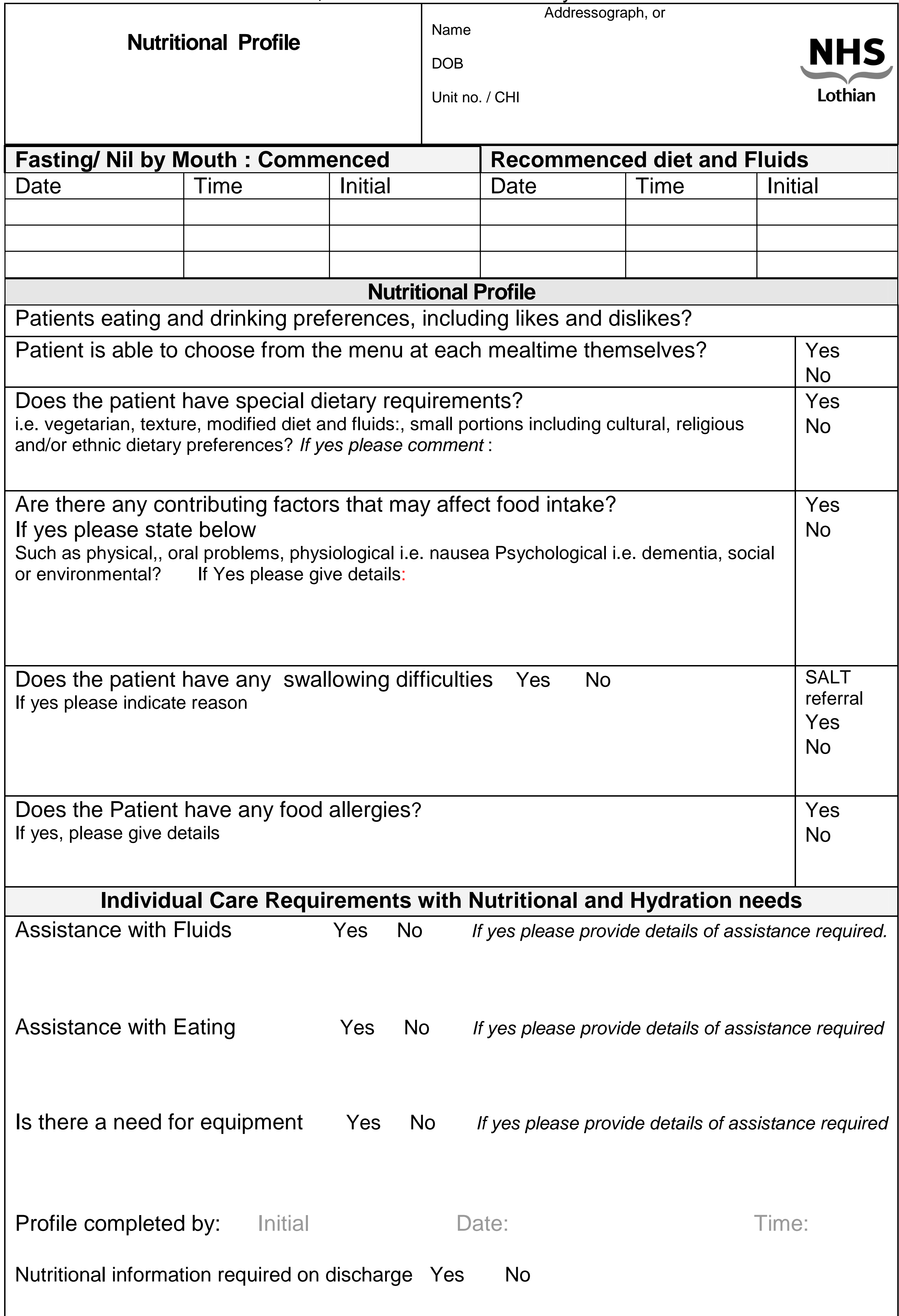
Date			**Week**	**Repeat assessment due:**		
Time						
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Date			**Week**	**Repeat assessment due:**		
Time						
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Weight Chart

Daily   Weekly   Twice Weekly   Please state:
Weight Chart only requires to be completed if clinically indicated

Date							
Weight KG							
Date							
Weight KG							



Nutritional Profile	Addressograph, or Name DOB Unit no. / CHI NHS Lothian

Fasting/ Nil by Mouth : Commenced			**Recommenced diet and Fluids**		
Date	Time	Initial	Date	Time	Initial

Nutritional Profile

Patients eating and drinking preferences, including likes and dislikes?

Patient is able to choose from the menu at each mealtime themselves?	Yes No
Does the patient have special dietary requirements? i.e. vegetarian, texture, modified diet and fluids:, small portions including cultural, religious and/or ethnic dietary preferences? *If yes please comment* :	Yes No
Are there any contributing factors that may affect food intake? If yes please state below Such as physical,, oral problems, physiological i.e. nausea Psychological i.e. dementia, social or environmental? If Yes please give details:	Yes No
Does the patient have any swallowing difficulties Yes No If yes please indicate reason	SALT referral Yes No
Does the Patient have any food allergies? If yes, please give details	Yes No

Individual Care Requirements with Nutritional and Hydration needs

Assistance with Fluids Yes No *If yes please provide details of assistance required.*

Assistance with Eating Yes No *If yes please provide details of assistance required*

Is there a need for equipment Yes No *If yes please provide details of assistance required*

Profile completed by: Initial Date: Time:

Nutritional information required on discharge Yes No