West Suffolk MUST Local Action Plan: Community teams

NHS West Suffolk NHS Foundation Trust

Screening to malnutrition and the risk of malnutrition

Screen for malnutrition using a validated screening tool such as the Malnutrition Universal Screening Tool (MUST)
Screening should take place on initial appointment and considered at other opportunities such as health checks, flu injections and repeated as per local policy or when there is clinical concern*.
Ask your patient or their NOK, if appropriate, regarding any history of weight loss or loss of appetite
Check patient can potentially meet nutritional needs safely via oral route
Record need for special diets and follow local policy

Obesity: Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity. Discuss with GP local weight management services if required.

MUST SCORE 0 = LOW RISK

- Routine clinical care
- Provide routine clinical care with annual repeat screening unless there is clinical concern or major clinical deterioration expected
- Encourage to maintain a balanced diet

Pressure Ulcers

Referrals for patients with a MUST score of ≥2 with a pressure ulcer of Grade 2 or above will be accepted if clearly stated on the referral

Oral Nutritional Supplements

ONS should not be used first line. A dietetic assessment is required to determine if a prescription is indicated, and which product is appropriate for the patient

MUST SCORE 1 = MEDIUM RISK Observe/Treat

Observe if weight stable or treat if weight is reducing or if rapid clinical deterioration anticipated.

Assess cause of malnutrition and take appropriate actions e.g. swallowing difficulties, oral health, impact of medication, mental health conditions or income

Set a goal with your patient such as weight gain, weight maintenance

Repeat screening least every 2-3 months and if MUST score changes follow appropriate plan

Plan (add 500kcal/day using leaflets below)
Assess food intake, aim to keep a 3-day food diary or ask patient to if possible. In inadequate intake provide the following advice:

- Encourage eating and drinking
- In between meal high calorie snacks: Nourishing snacks leaflet
- Homemade nourishing drinks daily: Nourishing drinks leaflet
- Fortified diet: Food fortification leaflet
- If patient is living with diabetes provide: Diabetes and nutrition support
- If clinical concern refer to GP

MUST SCORE 2 = HIGH RISK Treat

Treat - unless detrimental or no benefit from nutritional support expected e.g., imminent death

Assess cause of malnutrition and take appropriate actions e.g., swallowing difficulties, oral health, impact of medication, mental health conditions or income

Set a goal with your resident such as weight gain, weight maintenance

Repeat screening monthly and if MUST score changes follow appropriate plan

Plan (add 500kcal/day using leaflets below)
Assess food intake, aim to keep a 3-day food diary or ask patient to if possible. Provide the following advice:

- Encourage eating and drinking
- In between meal high calorie snacks: Nourishing snacks leaflet
- Homemade nourishing drinks daily: Nourishing drinks leaflet
- Fortified diet: Food fortification leaflet
- If patient is living with diabetes provide: Diabetes and nutrition support
- If clinical concern refer to GP

If they continue to lose weight after implementing the above for 4 weeks refer to the dietitian

***Clinical concern** Includes, for example, unintentional weight loss, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, altered taste sensation, impaired swallowing, altered bowel habit, loose fitting clothes or prolonged intercurrent illness

Please note there is a separate local action plan for care, nursing and residential homes.

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