Residential & Nursing Home Settings

Nutrition Care Plan: HIGH RISK OF MALNUTRITION ('MUST' SCORE 2+)

Name	Room	Date Care Plan initiated

Height metre/ft in	Weight 3 months ago: kg	Weight when care plan initiated: kg	BMI when care plan initiated: kg/m^2

If BMI >30 kg/m^2 (obese) treat according to local policy/national guidelines

Problems/Symptoms which are interfering with ability to eat and drink†	ONS prescription if provided
	Date commenced:
Treatment Goal:	Product Name:
	Daily Dose:

Initial and Date Each Box Monthly When Completed e.g. ✓HF, DD/MM/YEAR

	ACTION	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
1 Record	Record weight, BMI, 'MUST' score & risk category in notes						
	Agree goals of intervention (consider underlying symptoms and cause of malnutrition)						
	Record all food eaten for 3 days on food & fluid chart as a baseline and to monitor improvement or deterioration						
2 Treat	Follow local guidance or request prescription of oral nutritional supplements (ONS), e.g. 2 per day for 4 - 12 weeks* (record the details in the table above)						
	Utilise ideas from red leaflet Nutrition Drinks (known as Oral Nutritional Supplements) Advice for patients and carers www.malnutritionpathway.co.uk/library/pleaflet_red.pdf *The presence of acute or chronic illness may influence ONS prescription and duration**						
3 Monitor	Weigh weekly, re-screen using 'MUST' monthly or according to local policy and monitor compliance to dietary advice and ONS in notes						
	Review progress against goals (including review of this care plan) *(e.g. On improvement, consider managing as 'Medium Risk')* If no improvement after 4 weeks, or more specialist support required, consider referral to dietitian according to local policy						
	Evaluate goals e.g. if met or not met, when to stop ONS etc						

*For further information on dietary advice, powdered nutritional supplements and managing malnutrition according to risk, please visit www.malnutritionpathway.co.uk

Considerations

- When assessing weight loss during screening and re-screening make sure you compare weight with weight taken 3 months ago
- If unable to measure height use recall height – ulna measurement is an option if this is unavailable: http://www.bapen.org.uk/pdfs/must/must_page6.pdf
- If unable to measure weight use latest recall weight
- If weight and height cannot be obtained, use clinical judgement (e.g. clothes have become baggy, looking thin, swallowing problems) and/or measuring mid upper arm circumference (MUAC) to estimate a risk category but not a score. For further information: http://www.bapen.org.uk/pdfs/must/must_explan.pdf
- † 'Identifying the causes and symptoms which are interfering with the ability to eat and drink (e.g. swallowing issues, dry mouth, depression, nausea, early satiety) can help in identifying the most appropriate nutritional care. More information can be found at www.malnutritionpathway.co.uk/library/managing_malnutrition.pdf
- Goals of treatment should be agreed with the resident & malnutrition risk documented. Any treatment initiated should be monitored.
- 'At risk' residents should be reassessed as they move through care settings
- Consider whether a dietitian or speech and language therapist assessment is indicated in those in whom underlying conditions influence food choice e.g. in diabetes, or in where a condition affects the ability to eat and drink e.g. COPD, swallowing problems
- For more information see the malnutrition pathway care homes fact sheet - https://www.malnutritionpathway.co.uk/library/care_homes.pdf

Notes (e.g. food likes/dislikes/preferred foods):

Any other special nutritional requirements:

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