NHS Somerset NHS Foundation Trust

MUST Care Pathway for Care Homes in Somerset

MUST = 0 (low risk)

Re-screen monthly or if there is clinical concern

Examples of a clinical concern:

- unplanned weight loss (loose fitting rings/clothes)
- impaired swallow
- altered bowel habit
- prolonged illness
- ongoing poor appetite
- apathy or depression

Webinar for Carers

Watch the 25 minute webinar 'Supporting and screening for malnutrition in care homes' which provides additional information to support with a food first approach and a person centred nutritional care plan.

MUST = 1 (medium risk)

Food First Action Plan

1. Commence food chart to establish oral intake and assess likes and dislikes
2. Complete the Nutrition Support Care Plan booklet for resident to support with a Food First approach. This includes
   a. Adding food toppers to all meals
   b. Offering 2 nutrient dense snacks daily
   c. Offering 2 homemade milkshakes or nutrient dense puddings daily
3. Complete the Weekly Food First Prescription charts to document support offered

Re-screen using MUST after 1 month

MUST = 1

1. Continue to support with a Food First Action Plan
2. Repeat MUST monthly
3. Adapt care plan to suit needs of resident. For example, if resident is feeling too full with the above, consider offering less milkshakes and snacks and continue to monitor weight and MUST score monthly.

MUST = 2

Refer to MUST of 2 actions. Continue Food First Action Plan for 4-8 weeks and/or refer to dietitians if appropriate.

MUST = 2 (high risk)

Follow Food First Action Plan (as for MUST = 1)

Ensure GP is aware of malnutrition risk and notified of nutritional care plan

Re-screen monthly using MUST

Continue Food First Action plan for **4-8 weeks*.**
Re-screen sooner if concerned.

Continue Food First Action Plan if improvement

An improvement could be either of the following:

- No further weight loss or slowing of weight loss
- Weight stable (note: a variation of 5% is considered normal)
- Weight gain or MUST score improved

Continue Food First Action Plan and monitor monthly. Adapt care plan to suit needs of resident and continue to monitor monthly.

Consider dietetic referral if no improvement

If no improvement, e.g. further weight loss (more than 5%) and you have supported resident with the **Food First Action Plan** for 8 weeks* consider a dietetic referral using the **Community Dietetic Referral Form for Care Homes**.

***Consider sooner referral if resident has progressive neurological condition e.g. MND or Parkinson's disease AND significant dysphagia or reduced oral intake. Additionally if you feel your resident has complex or conflicting dietary needs then refer sooner for dietetic support.

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