





**Pan Dorset Malnutrition Programme**

**Care Pathways**

**June 2020**

 



**Introduction**

* 1. These care pathways were developed as part of the Nutritional Care Strategy for Dorset Adults. The strategy aimed to make a real difference to the problems of malnutrition and dehydration in Dorset's adult population. The Care Pathways are based on the following principles:
* Raising awareness amongst the adult population of Dorset adults enabling people to take on more responsibility and control for their own nutritional care by providing information, signposting and support as appropriate.
* Specific nutritional screening through the use of “MUST” (Malnutrition Universal Screening Tool) within health and care services.
* The transfer of relevant data between health and social care services.
* Promotion of good hydration practice.
  1. The pathways assume that an individual’s personal preferences, special diets and cultural requirements will be considered as paramount throughout!
  2. These pathways are not suitable for End of Life Care and any End of Life Care guidelines should override these pathways as appropriate.

**2. Safeguarding**

2.1 The Malnutrition Programme Care Pathways have been approved by the Pan Dorset Safeguarding Policy and Procedures Group as being good practice. These Pathways of Care state advice should be sort through the Safeguarding Triage Teams or via the Interagency Risk Management Protocol for any ‘MUST’ Score of 4. However, it is essential to realise that a lower or variable “MUST” score could still be a sign of deliberate or intentional neglect, and a similar referral should be considered if appropriate for anyone having a “MUST” score. For more information on adult safeguarding issues please refer to the [Multi-agency safeguarding adults policy](https://www.dorsetcouncil.gov.uk/care-and-support-for-adults/information-for-professionals/dorset-safeguarding-adults-board/dorset-safeguarding-adults-board-pdfs/multi-agency-safeguarding-adults-policy.pdf)

**Home and Community Care Pathway**

If a patient/client is on a special diet for medical reasons that may be affected by following the pathway please seek advice from the GP or Dietitian

**‘MUST’**

**Score 0**

**Low Risk**

If revisiting, review annually or reassess if circumstances change

If overweight/obese (BMI 25+) provide Change 4 Life for advice and Live Well Dorset information

**‘MUST’**

**Score 1**

**Medium Risk**

Discuss and encourage ‘Build Yourself Up’ Meals on Wheels and Luncheon Clubs

**‘MUST’**

**Score 4**

**Health and Social Care**

**Co-ordinators are informed automatically and will raise at an MDT or Virtual Ward meeting**

**‘MUST’**

**Score 2 or more**

**High Risk**

Discuss and encourage

‘Build Yourself Up’

Meals on Wheels and Luncheon Clubs

If you **are not** revisiting take appropriate actions and forward to Health & Social Care Co-ordinator

If you **are** revisiting in

Approx. 4 weeks repeat ‘MUST’

Follow the appropriate actions for new ‘MUST’ score

If you **are** **not** revisiting, take appropriate actions and forward to Health & Social Care Co-ordinator

If you **are** revisiting in

4 weeks repeat ‘MUST’

If weight has improved follow the appropriate actions for new ‘MUST’ score

If further weight loss or no improvement forward to Health & Social Care Co-ordinator to raise at an MDT or Virtual Ward meeting



**End of life**

**care guidelines should override this pathway**

The ‘Malnutrition Universal Screening Tool (‘MUST’) is adapted/reproduced here with the kind permission of BAPEN (British Association for Parenteral and Enteral Nutrition). For further information on ‘MUST’ see www.bapen.org.uk

**Actions to be taken by MDT’s and/or Virtual Wards**

***To be completed for patients who have had a ‘MUST’ /screening score of 2 or more for more than 2 months and no weight improvement***

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**‘MUST’**

**Score 2 or more**

**High Risk**

Discuss all of the following and action accordingly

1. Seek advice from Safeguarding Triage Team?
2. Arrange full medication review?

b) Refer to SLT

c) Is it a safe

Is it a safeguarding issue?

Ensure follow up in one month repeat ‘MUST’

Encourage Build Yourself Up

If weight **has** improved follow the appropriate actions for new ‘MUST’ score

If further **weight loss or no improvement refer** to Dietitian to consider prescribing ONS

**End of life**

**care guidelines should override this pathway**

If weight **has** improved follow the appropriate actions for new ‘MUST’ score

If **further weight loss or no improvement**



Ensure follow up appointment in one month

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**Home and Community Pathway Paper Form:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date:** | | **Name of person completing the screening:**  **Job title:** | | **Signature:** |
| **Name of Patient/ Client:**  **NHS Number:** | | **GP Practice:** | |  |
| **STEP 1**  Calculating ‘BMI’ via option a) or b) and converting to Score 0,1 or 2 | 1. If patient/ client **wishes** to be weighed and is **able** to be weighed:   Home Scales Staff Scales \*\*Refer to laminated sheet ‘Step **1** – BMI score (& BMI)’ for the score: 0, 1 or 2:  Record height (m) ………………………… Record weight (kg) ……………………… *\*\* Please see over for BMI help if needed* | | | |
| 1. If patient/ client **doesn’t** wish to be weighed or **can’t** be weighed:   **1**  **0**  Does Service User look at risk of being underweight? Yes : **OR** No: | | | |
| **STEP 2**  Calculating ‘Weight Loss Score’ via option a) or b) to give Score 0, 1 or 2 | 1. If patient / client **wishes** to be weighed and is **able** to be weighed:   Unplanned weight loss over 3-6 months (Kg): ……………….. \*\*Refer to “MUST” chart ‘Step **2** – Weight loss score’ for the score: 0, 1 or 2:  How was this calculated? ……………………………………………………………… *\*\* Please see over for weight loss calculation help if needed* | | | |
| 1. If patient/client **doesn’t** wish to be weighed or **can’t** be weighed:   **0**  **1**  Have they unintentionally lost weight over the last 3-6 months? Yes: **OR** No:  Reasons for each answer: ………………………………………………………………………………………………………… | | | |
| **TOTAL SCORE: STEP 1 + STEP 2 = ‘MUST’/Screening score** | | | | |
| **Actions taken:** | | | **Comments:** | |
| **Provide Change for Life (BMI 25+) & Live Well Dorset info** | | | **YES NO Comment:** | |
| **Discussed and encouraged Build Yourself Up** | | | **YES NO Comment:** | |
| **Discussed and encouraged Meals on Wheel / Luncheon Clubs** | | | **YES NO Comment:** | |
| **Discussed with Family/Carers** | | | **YES NO Comment:** | |
| **Anyone else informed eg other Providers/Carers/Caterers/other** | | | **YES NO Comment:** | |
| **Revisiting** | | | **YES NO If yes, date for next screening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Health and Social Care Co-ordinator informed** | | | **YES NO If Yes, why: a) ‘MUST’ score of 1 or more and not revisiting**  **b) ‘MUST’ score of 2 or more for 2 consecutive months** | |
| **Other actions/comments e.g. Contacted GP** | | | | |

**Step 1. Calculating BMI if service user wishes to be weighed.**

This will be done for you automatically when entering this form on to the Malnutrition Electronic System.

If patient / client doesn’t wish to be weighed or **can’t** be weighed, or you are unable to calculate BMI score then revert to Step 1 option b)

1. Use the “MUST” coloured chart **‘Step 1 – BMI score (& BMI)’**.
2. Plot the height of the patient / client along the top (feet/inches) or bottom (metres) line.
3. Move vertically up or down from this point plotting appropriate weight as it corresponds on the left (kg) or right (stones/pounds) axis.
4. Your finger should rest on a number between 8 and 47. This is the **BMI.**
5. In order to translate this into the **‘MUST’ BMI** score refer to the ‘Score’ number (0, 1 or 2) written in blue.

This is the number to enter for the paper form ‘Step 1 calculate BMI’ when the patient / client has been weighed.

**Step 2. Calculating unplanned weight loss if patient / client wishes to be weighed**.

This will be done for you automatically when entering this form on to the Malnutrition Electronic System.

If patient / client **doesn’t** wish to be weighed or **can’t** be weighed and weight loss is noticeable, score 1.

Only record **unplanned** weight loss. **Planned** weight loss should be recorded as ‘0’ and appropriate comments written e.g. ‘lost weight but on a planned diet’.

1. The patient / client‘s weight 3 to 6 months ago may be available from the system/notes/knowledge. If not available but noticeable from clothes, photos or by family/friends or patient/ client comments assume 7kg (a stone) for an average sized person or 10kg (stone and a half) for a bigger person. If it is extremely noticeable increase the weights accordingly.
2. Using “MUST” weight loss chart **‘Step 2 – Weight loss score’:** Plot their weight from today on the cream coloured column ‘Current weight’.
3. Move along horizontally till you come to what you know or think their weight was 3 to 6 months ago.
4. Your finger should rest on one of the following columns with a corresponding score:

**Green** column Score 0 **Yellow** column Score 1 **Red** column Score 2

Enter 0, 1 or 2 on the paper form ‘Step 2 calculate Weight Loss Score’ when patient / client has been weighed.