# Nutritional Screening and First Line Oral Nutritional Care Policy for Adults

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| **Name of Responsible Committee/Individual:** | **UHL Trust Nutrition and Hydration Assurance Committee** |
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**REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW**

**October 2020**

Changes made include: MUST On NerveCentre and procedure for completion, updated Nutritional Care Plan and Poster, Resources links updated, Patient Information Resources updated

**October 2023**

Complan oral nutritional supplement product updated to Aymes range, inpatient MUST completion within 12 hours on a base ward, monitoring section updated to reflect ward accreditation and assessment and PLACE


## KEYWORDS

Nutrition Screening, Nutritional Support, Malnutrition, MUST

## 1. INTRODUCTION

1.1. This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy for adult nutritional screening and instigation of first line oral nutritional support at ward/unit level and in outpatient clinics. It is estimated that, at any one time, at least three million adults in the UK are affected by malnutrition. The more vulnerable at risk groups include those with chronic diseases (for example cancer, renal, liver, heart failure, chronic obstructive airways disease), the elderly, those recently discharged from hospital and those who are poor or socially isolated. Using nutritional screening, malnutrition risk has been identified in 30% of all hospital admissions (ranging from 43% in gastrointestinal patients to 17% of musculoskeletal patients) (BAPEN, 2014).

1.2. This Policy defines the procedure for adult nutritional screening to identify patients who are malnourished, or those at risk of malnutrition. It provides guidance on how to recognize which patients are likely to benefit from oral nutritional support interventions, and outlines options for first line oral nutritional support. It outlines the processes to follow to identify patients who are at nutritional risk, how nutritional status can be improved, what support there is available from members of the multidisciplinary team and how education and training can be accessed. The process identifies 'at risk patients' who require extra measures to boost their dietary intake, followed by close monitoring, and this is discussed in detail. It also highlights patients that require direct referral to the Dietetic and Nutrition Service. It is generally completed electronically on NerveCentre described in detail in Appendix 1, with paper documentation available for downtime purposes in Appendix 3.

1.3. Nutritional screening and oral nutritional support are key standards in the following National guidance and by achieving the care in this Policy it will allow the Trust to meet these requirements:

- Nutritional support for adults: oral nutritional support, enteral tube feeding and parenteral nutrition. National Institute for Clinical Excellence (NICE), Clinical Guideline (CG32). Published 22 Feb 2006. Last Updated 04 Aug 2017.
- Standards and Guidelines for Nutritional Support of patients in hospitals. British Association of Parenteral and enteral Nutrition (BAPEN).2012.
- The 10 key characteristics of good nutrition and hydration care from the NHS England. 2015.
- Nutrition and Hydration Digest. The British Dietetic Association. 2023.
- Malnutrition Universal Screening Tool (BAPEN). First published May 2003 by the Malnutrition Advisory Group (MAG), A Standing Committee of BAPEN. Reviewed and republished March 2008, September 2010 and August 2011.
- Patient Led Assessments of the Care Environment (PLACE), 2013

1.4. Malnutrition is frequently undetected and untreated causing a wide range of adverse consequences. Some adverse effects of malnutrition include:

- Impaired immune responses – increasing risk of infection
- Reduced muscle strength and fatigue – impairing rehabilitation

- Reduced respiratory muscle function – resulting in increased difficulties in breathing, in turn increasing the risk of chest infection and respiratory failure
- Impaired thermoregulation – predisposition to hypothermia
- Impaired wound healing. Delayed recovery from illness/surgery
- Apathy, depression and self-neglect
- Increased risk of admission to hospital, increased length of stay and risk of re-admission
- Poor fertility, pregnancy outcome and mother child interactions

In hospital, patients at risk of malnutrition stay in hospital longer, and are more likely to be discharged to health care destinations other than home, e.g. nursing homes and be re-admitted.

Water/fluid also frequently gets overlooked as a basic nutrient and evidence for good hydration shows that it can assist in preventing pressure ulcers, urinary infections, constipation, falls, cognitive impairment and many other conditions.

## 2. POLICY AIMS

2.1. This Policy aims to reduce risk by identifying patients with clinical malnutrition or those at risk during their hospital admission and when attending outpatient clinics, so appropriate treatment can be given. Nutritional screening within the Trust is primarily focused on identifying those patients already malnourished, or at risk of malnutrition (under nutrition). This Policy emphasizes clinically identifiable protein-energy malnutrition.

## 3. POLICY SCOPE

3.1. This policy applies to all medical, nursing, and allied health care professionals who care for adult patients' nutrition needs. This policy also applies to catering and facilities staff responsible for and involved in the Trust catering service which forms part of oral nutritional support.
3.2. This policy applies to adult inpatients and outpatients.
3.3. This policy does not cover patients with single nutrient deficiencies. Information on management of single nutrient deficiencies eg iron anaemia, vitamin D deficiency in pregnancy and vitamin D deficiency in adults can be accessed on the Leicester, Leiecestershire and Rutland Area Prescribing Committee (LLRAPC).
3.4. This policy does not cover the management of patients who are identified as morbidly obese or obese through the screening process. For information on Dietary Management of Adult Bariatric Surgical Patients see Guideline Ref C56/2015.
3.5. This policy does not cover patients requiring a therapeutic diet to treat or control a condition/disease e.g. renal diet, or a special diet e.g. cultural or religious diet.
3.6. This policy does not cover artificial enteral interventions. For Policies and Guidelines on Adult Enteral Nutritional Support see Ref B55/2006, B30/2019, B62/2019.B6/2019, C2/2015, C24/2020 and B39/2005.
3.7. This policy does not cover artificial parenteral nutritional support interventions. For Policies on Adult Parenteral Nutritional Support see Ref B22/2015.

## 4. DEFINITIONS

4.1. **Nutritional screening** refers to a rapid, simple, general often initial evaluation undertaken by healthcare professionals, to detect significant risk of malnutrition and to implement a clear plan of action, such as simple dietary measures or referral for expert dietetic advice. All patients should be screened unless they fall under the exclusion criterion in section 6.5 with the aim being to identify any patients at risk of clinical malnutrition.

4.2. **Nutritional assessment** is a more detailed, more specific and in-depth evaluation of an individual patient's nutritional status, undertaken by an individual with nutritional training, e.g. a Dietitian or by a nutrition support team (NST).
The terms "nutritional screening" and "nutritional assessment" are not interchangeable. The aim of this Policy is to look at nutritional screening.

4.3. **Malnutrition** is a state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition) and function and clinical outcome.

4.4. The "**Malnutrition Universal Screening Tool**" **(MUST)** is the recommended nutritional screening tool for the trust, supporting NICE guidance (2012), to screen using objective measurements of weight, height, body mass index and recent percentage weight loss. A score is calculated indicating overall risk of malnutrition and appropriate management.

4.5. **Nutritional support** is an active measure(s) put in place to help improve nutritional intake. This could be oral and/or enteral and/or parenteral to address malnutrition.

4.6. **Oral nutrition** can be food ie fortified food, additional snacks, fluids and non prescription and prescription oral nutritional supplements.

4.7. **Hydration** applies to any fluid consumed. Foods that have a high fluid content eg jelly or ice cream will support good hydration.

## 5. ROLES AND RESPONSIBILITIES

5.1. The **Executive Lead** for this Policy is the Chief Nurse who has overall responsibility for ensuring patient care and safety, including nutritional management.

5.2. The **Assistant Chief Nurse (Education)** has responsibility to ensure that adequate arrangements are in place to:

- **a)** Ensure the trust is compliant with national and local targets
- **b)** Support the implementation of the trust Adult Nutritional Screening First line nutritional care policy.

5.3. **Heads of Nursing/ Deputy Heads of Nursing** are responsible for ensuring that adequate arrangements are in place to:

**a)** Ensure the Trust Adult Nutritional Screening First Line Nutritional Care Policy is implemented in their CMG.

**b)** Monitor and validate the Nursing Metrics for Nutrition within their Clinical Management Group focusing on wards / units with high non-compliance with standards.

**c)** Sign off Serious Incidents (SI) reports and ensure actions are implemented.

5.4. **Ward Sisters / Unit Sisters / Charge Nurses** are responsible for:

**a)** Ensuring that all staff receive information, instruction and training on the key aspects of this policy at induction. This training should be accessed on HELM under Nutritional Screening: A MUST for hospitals (e learning) and / or ward level as a minimum requirement and relevant to their working areas and duties. It has no expiry date. See section 7 for more details.

**b)** Investigating reported incidents / near misses and complaints linked to nutritional care and ensuring any remedial action is identified and implemented. Seeking advice from the Nutrition and Dietetic Service / Dietetic Practice Learning Lead in the assessment of root causes and if investigation at a higher level is required.

**c)** Ensuring nutritional screening using the MUST and nutritional care plans are completed with the Trust procedures electronically and where indicated manually.

**d)** Ensuring the nutrition metrics are audited monthly using the monthly performance review tool and monitored closely on a quarterly basis.

**e)** Identify a named Nutrition Link Nurse for each ward/unit and outpatient area.

**f)** Raise ward staff awareness of the need to ensure points 5.5 a to j below are followed.

5.5. **Registered Nurses and Nursing Associates** are responsible for:

**a)** Weighing patients on admission and recording on body weight chart

**b)** Completing the patients' initial nutritional screening tool on admission and weekly during the patient stay and on discharge

**c)** Planning patient care in response to the nutritional screening results

**d)** Initiating the first line oral nutrition care plan as indicated

**e)** Staff should continue to follow the first line nutritional care plan unless clinically inappropriate eg patient is nil by mouth or the ward Dietitian advises an alternative oral nutrition care plan. Referring the patient to the ward Dietitian when the nutritional screening tool score is 4 or more.

**f)** Communicating with the ward team such as Housekeepers and Health care assistants all patient care nutrition needs

**g)** Communicating with catering assistants regarding any menus or support menus required by inpatients

**h)** Providing direct support to patients to help them meet their nutritional needs

**i)** Monitoring and documenting patients' nutritional status eg food intake recorded on food record charts and body weights

**j)** Reviewing patients nutritional progress and if there is no improvement or deterioration on the present plan consider referring to the ward Dietitian

5.6. **Health Care Assistants and Housekeepers** are responsible for:

**a)** Being aware of patients' nutritional care plan requirements and providing direct support to patients to help them meet their nutritional needs

**b)** Ordering and providing first line oral nutrition support interventions e.g snacks, Aymes Shakes, Soups and Smoothie drinks and providing these to the patient

**c)** Monitoring and documenting patients' nutritional status eg food intake recorded on food record charts and body weight recorded on weight charts

**d)** Report changes and escalate any concerns to the Registered Nurse in charge of the patients care

**e)** Undertaking stock control at ward level of first line oral nutritional support interventions e.g. snacks, Aymes Shakes, Soups and Smoothies, milk and ordering top up supplies using the daily ward requisition form and submitting to Catering Services

5.7. The **Medical Team** are responsible for:

**a)** Ensuring the nutritional status of patients is assessed as part of admission, board rounds, ward rounds and on discharge where applicable

**b)** Acting upon concerns raised by healthcare professionals if the patients' oral nutritional intake is insufficient to meet their nutritional needs

5.8. **The Catering Assistants** are responsible for:

**a)** The provision of supplies to the wards of first line oral nutritional support interventions e.g. milk, snacks and provision of non prescription oral nutritional supplements e.g. Aymes Shakes, Soups and Smoothies via daily ward requisitions.

**b)** They should communicate with ward nursing staff to ensure red trays are provided where needed.

**c)** They should communicate with the ward nursing team and ward Dietitian about support menus and therapeutic diets required.

**d)** They should take a food order for each patient on the ward and communicate with ward nursing if an inpatient opts not to order any food or their food order is minimal i.e. soup only.

5.9. **Dietitians** are responsible for:

**a)** Providing Trust wide training on the valid use of the nutritional screening tool and first line nutritional care plan as part of Trust wide training programmes such as: Perceptorship nurses, International nurses and Nutrition Study Sessions on HELM

**b)** Providing Clinical Management Group (CMG), speciality and ward based training on the valid use of the nutritional screening tool and first line nutritional care plan when requested or when review of risk management issues training is indicated

**c)** Acting upon dietetic referrals from ward nursing staff and nutritionally assessing the patient and providing an individualised care plan

**d)** Undertaking a nutritional assessment of patients referred using factors such as weight, weight history, height, body mass index, history of recent intake, hydration, blood biochemistry and influence of disease state on nutritional status.

**e)** Providing an individualised nutrition care plan for patients referred after nutritional assessment and documenting this in medical and nursing notes at ward level

**f)** Interpreting and monitoring the nutritional documentation eg food record charts and body weights held at ward level

**g)** Escalating concerns with patients who are not meeting nutritional requirements to the medical team

**h)** Providing supplementary clinical audits on nutritional screening and first line nutritional care to the nursing metrics as part of a fresh pair of "eyes and ears" approach and providing timely feedback on any areas of concern to allow them to be addressed.

5.10. **Specialist Nurses** are responsible for:

**a)** All specialist nurses should ensure as a patient's key worker that nutritional care has been considered in the patients care plan

**b)** Nutrition and Tissue Viability specialist nurses need to ensure nutritional screening and first line nutritional care is covered in nutrition and tissue viability link nurse training and education sessions

**5.11. Allied Healthcare Professionals (AHP's) are responsible for providing support to the meal time experience where appropriate/where referred:**

**a) Speech and language therapists (SLT)** provide a referral- screening tool for patients suspected of having difficulties swallowing their food or drink. The SLT team will undertake a swallow assessment. SLT recommendations will aim to reduce risks of aspiration and choking and promote safe eating and drinking.

**b) Occupational Therapists (OT)** will undertake an OT assessment that will be carried out at meal times in order to determine whether the patient is independent or having difficulties with feeding. Aspects such as environment, cutlery and kitchen practice will form part of the assessment.

**c) Physiotherapy (PT)** can provide input in terms of assessments of mobility and transfer, posture ability and positioning and upper limb range of movement and strength.

## 6. POLICY STATEMENTS AND STANDARDS

6.1. Healthcare professionals involved in starting or stopping oral nutrition support should consider ethical and legal issues. In terms of the law, provision of food and drink by mouth is deemed as basic clinical care. Artificial nutritional support such as enteral or parenteral nutrition is deemed as a medical intervention by the law.

### 6.2. Nutritional Screening Tool to identify clinical malnutrition

**The "Malnutrition Universal Screening Tool (MUST) is the adult nutritional screening tool of choice for UHL NHS Trust.** See Appendix 1 for the electronic version of MUST used on NerveCentre. See Appendix 2 on instructions for use of MUST on NerveCentre. See Appendix 3 for manual version of MUST in the event of down time/failure of NerveCentre. Using objective measurements of weight, height, body mass index, recent percentage weight loss and acute disease effect. A score is calculated indicating overall risk of malnutrition and appropriate nutritional management.
The "MUST" has been evaluated in hospital wards, outpatient clinics, general practice, and the community and in care homes. It has been found to be easy, rapid, reproducible and internally consistent.
The "MUST" can be used in patients in whom weight and height are not obtainable, as a range of alternative measures and subjective criteria are provided. The tool has face validity, concurrent validity and predictive validity. In hospitals, the "MUST" predicts length of stay, discharge destination and mortality after controlling for age.

### 6.3. UHL Trust Standards for nutritional screening

**Early identification of malnourished patients or those at risk is vital.**
Proactive nutritional screening in hospital is recommended for the whole of the target population. The Trust's nutritional screening programme should be regarded as an integral part of clinical care.
**All inpatients are to be screened using the "Malnutrition Universal Screening Tool" (MUST) as follows unless exempt (see section 6.5).** All adult hospital inpatients on base wards must be nutritionally screened on admission within 12 hours of arrival to that area by staff with appropriate skills and training using the Malnutrition Universal Screening Tool (MUST) unless exempt. (see section 7).

Nutritional screening must be repeated weekly during hospital stay or more frequently if clinically indicated again using the Malnutrition Universal Screening Tool (MUST). All adult inpatients must be nutritionally screened prior to discharge as part of discharge planning. If patients are being transferred to other care facilities such as community hospitals, care homes a recommendation should be made to continue ongoing nutritional screening and the nutritional care plan.

**All hospital outpatients are to be screened using the "Malnutrition Universal Screening Tool" (MUST) as follows unless exempt (see section 6.5).**
All hospital outpatients should be nutritionally screened at their first clinic appointment using the Malnutrition Universal Screening Tool (MUST). There is a pathway in place to guide this "Managing Malnutrition in UHL Adult Out-patient Clinics using "MUST", the pathway links to patient information leaflets to be used for patients where risk is found, and guides referral to the Dietetic and Nutrition Service. Screening should be repeated when there is clinical concern for outpatients eg continued weight loss.

Planned elective surgical patients should be screened using the attending pre-assessment clinic appointments should be nutritionally screened using the Malnutrition Universal Screening Tool (MUST) where there is a clear evidence base, e.g. pre-operative cancer surgical patients and all elderly patients. Consideration will need to be given to other schemes eg Making Every Contact Count (MECC) for obesity management depending on the evidence base for both. Each CMG will need to confirm practice using clear evidence base and rationale. Audits with an acceptable sample size will help inform the need to nutritionally screen specific groups in the absence of a clear evidence base and rationale. Groups of patients to be exempted from nutritional screening should be registered with the Trusts Nutrition and Hydration Assurance Committee.

### 6.4. Patients for nutritional screening and referral to Dietitian

Patients with the following conditions must be referred to the Dietitian under local blanket referral Policy (as part of pre-determined clinical care pathways). These include:

- Grade 3 and Grade 4 pressure sore patients
- Gastro-oesophageal cancer patients
- Head and Neck cancer patients
- Bone marrow transplant cancer patients
- Pancreatic cancer patients
- Intensive care patients (Level 1)
- End stage Renal Failure on or about to start dialysis
- Acute renal failure patients
- Newly transplanted with a kidney
- Patients with infection such as Clostridium Difficile and Covid 19 inpatients

The nutritional parameters measured and monitored by screening and implementing first line nutritional support are still relevant to these patients. Therefore nutritional screening must still be undertaken at ward level and the above patients must be referred to the ward/unit Dietitian regardless of the score for individualised nutritional assessment.

### 6.5. Exemptions to Screening

The following clinical areas with groups of patients with low risk of malnutrition may opt out of screening (See Table 1). NB Individual patients within these Specialities should be referred for nutrition support if there is concern over malnutrition risk using clinical judgment.

**Table 1: Groups of patients exempt from Nutritional Screening Programme**

| Clinical Management Group | Speciality | Patient Category and Setting eg. Inpatient/ Outpatient/ Day-case | Rationale |
|---|---|---|---|
| Women's | Gynaecology<br><br><br><br>Obstetrics | Inpatients – non cancer diagnosis of < 65years admitted for elective procedures, e.g. hysterectomy All pregnancy | Deemed at low risk.<br><br><br><br>MUST invalid in this patient group |
| Trust-wide | | Those on End of Life Care (EOLC) / Patients in the Emergency Department | Nutritional interventions are not indicated and screening is not appropriate<br>Not indicated as part of ED assessment |
| Outpatients | Dermatology Sleep Clinic<br>Orthopaedics at GH<br>Screening programme clinics (as a public health initiative)<br>Cystic Fibrosis clinic (as dedicated specialist dietitian input for all patients) | | |

### 6.6. Procedure for Adult Nutritional Screening

See Appendix 2 for Adult Nutritional Screening procedure when using NerveCentre.

Links to support resources for MUST which can be used in clinical areas directly with patients or in the event of NerveCentre being down a manual calculation having to be undertaken are:
The full "MUST" Tool Kit:-

- Guide to the five steps of 'MUST': https://www.bapen.org.uk/pdfs/must/must_page1.pdf
- 'MUST' flow chart: https://www.bapen.org.uk/pdfs/must/must_page3.pdf
- BMI Chart: https://www.bapen.org.uk/pdfs/must/bmi-weight-loss-charts/must-table-up-to-100kg.pdf
- Weight Loss Chart: https://www.bapen.org.uk/pdfs/must/bmi-weight-loss-charts/kg-only-30to169kg-previous.pdf
- Alternative measurements: https://www.bapen.org.uk/pdfs/must/must_page5.pdf
- Alternative measurements (illustrations): https://www.bapen.org.uk/pdfs/must/must_page6.pdf

These can be used along with the paper documentation in Appendix 3 during NerveCentre downtime/major incident available via the hospital print rooms.

### 6.7. Procedure for first line oral nutritional support management

This procedure outlines the interventions to be provided at ward level as part of the first line oral nutritional support care plan that should be followed and in place for all patients with a MUST score of 1 or more. The interventions include main menu options, snack options, milk, non prescribable nutritional supplements from the Aymes Shakes, Soups and Smoothies range and snack bags. Linkage with ward based systems eg Board rounds, Red Tray system and Enhanced Meal Times is included.

Exceptions: patients who should not follow first line oral nutritional support advice are:-

- Patients where normal oral nutrition is contraindicated for example dysphagia with risk of aspiration.
- Patients with renal disease, lactose intolerance, metabolic or cow's milk allergy should not be offered milk based fluids (including Aymes Shakes, Soups and Smoothies supplements.)
Liaise with your ward Dietitian for further advice in these instances.
All other aspects of the first line nutritional support advice are relevant to all patients.
- See Appendix 4 for First Line Oral Nutritional Care Plan

- See Appendix 5 for First line Oral Nutritional Support poster for wards

Working together as a team ward staff can make a real difference to the nutritional intake achieved by patients at ward level, and the importance of first line nutritional care plan measures should not be underestimated.

Patient information resources to support oral nutritional support care planning and interventions can be found on the Trusts Your Health Website. Access using the following steps:

If you go to Insite and put ' Your Health' in the search facility

Then a section comes up Insite Your Health, click on this

Then put in 'going home' into second search box, a range of leaflets come up

Or website link: http://yourhealth.leicestershospitals.nhs.uk/

See patient information leaflet on your health in hospital:-
http://yourhealth.leicesterhospitals.nhs.uk/library/csi/dietetics/1070-eating-enough-to-support-your-recovery-in-hospital

See patient information leaflet on your health at home:-
http://yourhealth.leicesterhospitals.nhs.uk/library/csi/dietetics/1070-eating-enough-to-support-your-recovery-at-home

### 6.8. Procedure for documentation and clinical monitoring

- See Appendix 6 for procedure for documentation and clinical monitoring of food and fluid intake
- See Appendix 7 for body weight chart
- See Appendix 8 for food record chart

NerveCentre and obs should be used to sign post actions required for nutritional monitoring by nursing and dietetic staff.

### 6.9. Onward referral / expert advice

Nutritional screening links with referral to the Dietetic & Nutrition Service, and is a key element of the UHL standardised nursing documentation and NerveCentre electronic referral systems.
The following groups of patients should be referred directly to the Nutrition and Dietetic Service:

- MUST score is 4 or more
- MUST score increases on repeated nutritional screening
- Body weight drops by > 1kg on repeated nutritional screening
- There is clinical deterioration on high risk care plan
- A full dietetic nutritional assessment is required in response to clinical judgment
- Enteral tube feeding e.g. nasogastric, percutaneous gastrostomy is required
- Patient requires a therapeutic diet, e.g. metabolic, renal, food allergy diet
- Patient requires a cultural/religious diet where nutritional intake is known/suspected to be poor/insufficient, e.g. pregnant vegan patient
- Patient requires a modified consistency diet where nutritional intake is known/suspected to be poor/insufficient, e.g. male, 50 years, 90kg, recent stroke on pureed diet
- Patients admitted already on prescribed oral nutritional supplements and/or enteral tube feeds for a review of their nutritional care plans
- Patients covered by local blanket referral policy listed in point 6.4

NB. Patients requiring parenteral nutrition must be referred to the Adult Nutrition Support Team on each site. Some groups of patients should be referred to the ward Dietitian under local blanket referral (see point 6.4).

The ward Dietitian may consider the use of other measurements in the nutritional assessment and monitoring of long term patients, e.g. use of mid-arm circumference (MAC) in patients with abnormal fluid balance or if unable to be weighed.

MAC measurements will be taken by the same Dietitian and Dietetic Assistant to avoid inter-observer variability.

### 6.10. Discharge Planning

- All adult inpatients should be nutritionally screened prior to discharge as part of discharge planning. The MUST score and first line oral nutritional care plan should be communicated on the discharge planner to the destination the patient is being transferred to. Advice provided on discharge may be supported by a patient information advice leaflet.
- Ensure that prior to discharge high risk patients are reviewed by the ward Dietitian. Please inform Ward Dietitian in advance of planned discharge date. If the patient is discharged on oral prescribable nutritional supplements the ward Dietitian will send the GP a case of need for further prescriptions, outlining the ONS product(s) required, volume, frequency and flavours expected length of time these will be required and the on-going monitoring plan via ICE letter.

## 7. EDUCATION AND TRAINING REQUIREMENTS

### 7.1. Education and Training Requirements

Screening for malnutrition and risk of malnutrition should be carried out by healthcare professionals with the appropriate skills and training. An e-learning session 'Nutritional Screening: A MUST for Healthcare in Hospital' is available on the HELM system. It should be completed by all ward nursing staff working within the Trust as essential to role training; a certificate of completion can be downloaded once the pass rate has been achieved. This has no expiry date.

### 7.2. Training

Training is available to support the use of this clinical policy and procedures via the Nutrition and Dietetic Service at ward and CMG level. Staff will need to be able to:

- Accurately complete the MUST nutritional screening tool
- Implement an appropriate nutritional care plan according to the MUST score, including initiating 1st line oral nutritional care plans and referral to the ward Dietitian when appropriate
- Monitor patient's nutritional progress, and review nutrition care plan as necessary
- Advise and assist patients to manage different diseases / conditions treated by diet treatment
- Refer to the ward Dietitian
- Discharge planning including nutritional care for patients

Elements of these areas are currently included in UHL Healthcare Assistant induction sessions, preceptorship training, and international nurse training, and these sessions should include clear reference to this policy.

Ward nursing staff and other members of the multi disciplinary health care team have access to e learning on adult nutritional screening using the MUST tool on HELM; 'Nutritional Screening : A MUST for Hospitals'

https://uhlhelm.com/login/?redirect_to=http%3A%2F%2Fuhlhelm.com%2F&reauth=1

Found by going into the course catalogue and putting nutrition into the search bar.

Ward nursing staff have access to two face to face nutrition study sessions which can be booked on HELM. These are provided by the Trusts Dietetic Practice Learning Lead and include:
Session A: Nutritional Screening and First Line Nutritional Care
Session B: Nutritional Interventions and Monitoring

Other trust-wide training such as dementia training, older person champion training, housekeeper training, tissue viability study days, outpatient staff and mealtime assistant volunteer training should all make reference to this policy.

Contractors such as catering staff should also receive training that refers to this policy.

7.3. Results from nutrition audits; the nursing metrics – nutrition metrics, and the CQUIN unintentional weight loss audit may highlight areas of the trust where further nutrition training in nutritional screening and nutritional support would be beneficial, at present this can be delivered by the Dietetic practice learning lead post.

7.4. Students and trainees on placement within the Trust should be supported in learning these key nutritional skills and sessions on nutrition will be delivered to the Inter Professional Learning Programme (IPL) by the Trusts Dietetic Practice Learning Lead making clear reference to this policy.

7.5. Other helpful training can be accessed on line through the National skills Academy for Health, This is interactive and the learner can develop at their own pace and can save their learning and return later. Staff will need to register with an NHS e-mail, but there after can access outside NHS premises. See https://elearning.nsahealth.org.uk, currently modules are available on

- Introduction to food and nutrition
- Under nutrition and dehydration
- Facilitating and supporting eating and drinking
- Assisting with eating and drinking
- Best practice benchmarking for nutrition care
- Basics of nutrition and hydration

## 8. PROCESS FOR MONITORING COMPLIANCE

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements |
|---|---|---|---|---|
| All of the Policy: nutritional screening, repeat screening, care planning, nutritional first line interventions, monitoring and discharge planning | Chief Nurse | Nursing Metrics – Nutrition Metrics | Monthly | UHL Harm Free Care Group (HFCG) and Trust Nutrition and Hydration Assurance Committee |
| All of the Policy: nutritional screening, repeat screening, care planning, nutritional first line interventions, monitoring and discharge planning | Chief Nurse | Trust exemplar standards | Programme | UHL Harm Free Care Group (HFCG) and Trust Nutrition and Hydration Assurance Committee |
| All of the Policy: nutritional screening, repeat screening, care planning, nutritional first line interventions, monitoring and discharge planning | Director of Estates and Facilities | PLACE standards nutrition section | Programme of hospital site visits | Trust Nutrition and Hydration Assurance Committee |
| All of the Policy: nutritional screening, repeat screening, care planning, nutritional first line interventions, monitoring and discharge planning linked to risk management eg cluster of incidents, coroners inquests | Head of Service for Nutrition and Dietetic Service | Tailored to audit question at local Level | As indicated | Speciality and CMG level |

## 9. EQUALITY IMPACT ASSESSMENT

9.1. The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

## 10. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES


- • National Standards for Health Care Food and Drink, 2022
- Nutritional support for adults: oral nutritional support, enteral tube feeding and parenteral nutrition. National Institute for Clinical Excellence (NICE), Clinical Guideline (CG32).
- Published 22 Feb 2006. Last Updated 04 Aug 2017. https://www.nice.org.uk/guidance/cg32 [accessed 12.10.2020].
- • Standards and Guidelines for Nutritional Support of patients in hospitals. British Association of Parenteral and enteral Nutrition (BAPEN).2012.
- • The 10 key characteristics of good nutrition and hydration care from the NHS England. 2015. https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ [accessed 12.10.2020].
- Nutrition and Hydration Digest. The British Dietetic Association. 2023, 3rd edition.
- https://www.bda.uk.com/specialist-groups-and-branches/food-services-specialist-group/nutrition-and-hydration-digest.html [accessed 12.10.2020].
- Malnutrition Universal Screening Tool (BAPEN). First published May 2003 by the Malnutrition Advisory Group (MAG), A Standing Committee of BAPEN. Reviewed and republished March 2008, September 2010 and August 2011.
- https://www.bapen.org.uk/pdfs/must/must-report.pdf [accessed 12.10.2020].
- Care Quality Commission, 2009. Core Standard https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers, [accessed 12.10.2020].
- Department of Health. 2010. Essence of care https://www.gov.uk/government/publications/essence-of-care-2010[accessed 12.10.2020
- Department of Health. 2001. National service framework for older people.
- https://www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people [accessed 12.10.2020].
- National Collaborating Centre for Acute Care, 2006. Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition, London
- https://www.nice.org.uk/guidance/cg32/evidence/full-guideline-194889853 . [accessed 12.10.2020].


## 11. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.
The Policy will next be reviewed in November 2023. The review will be led by the Head of Service for the Trusts Dietetic and Nutrition Service.

## Appendix 1: Electronic Malnutrition Universal Screening Tool (MUST) on NerveCentre

## Appendix 2: Procedure for nutritionally screening using "MUST" including documenting on NerveCentre

### EQUIPMENT YOU WILL NEED:

- Access to Nerve centre
- Weighing scales
- Height measure

To implement actions (when patients score 1+)

- UHL standard nursing documentation – Weight chart
- UHL standard nursing documentation – Food chart
- UHL standard documentation for those - First line oral nutritional care plan

In case of electronic downtime

- MUST tool kit with; BMI chart and %weight loss chart
- UHL standard nursing documentation – 'MUST' part of risk assessments
- Height and weight conversion charts.

### METHOD / PROCESS OFCALCULATION:

1. Gather nutritional measurements:

   A) **Weight of patient in Kg**.

   - Weigh patient in light clothing
   - Use clinical weighing scales (category iii or higher) which have been regularly calibrated (at least annually)
   - Ensure they read zero without the patient on them
   - Ensure the patient is sitting or standing in the correct position (e.g. not leaning on a wall and feet off the ground)
   - Before recording check the weight reading taken correlates to the appearance of the patient and/or to previous readings recorded.
   - If there are factors present that influence body weight e.g oedema ascites or amputation these should be clearly documented with the weight.
   - An attempt should be made to weigh all patients, if unable to weigh a patient document the reason and ask the patient or relative or carer to recall or estimate weight, or review the medical notes for recently recorded weight.
   - For patients with ascites or oedema a dry weight can be estimated by subtracting the weights in the chart below accordingly:

| | ASCITES | PERIPHERAL OEDEMA |
|---|---|---|
| Minimal | 2.2 kg | 1.0 kg |
| Moderate | 6.0 kg | 5.0 kg |
| Severe | 14 kg | 10.0 kg |

B) **Height of patient in metres**.

- Use a height stick (audiometer) where possible, ensure correctly positioned against the wall
- Ask patient to remove shoes, stand upright, feet flat and heels against height stick or wall
- Make sure the patient is looking straight ahead, and lower the height plate until it gently touches the top of the head.
- An attempt should be made to obtain a height measurement for all patients. If unable to measure document reason and ask the patient, relative or carer to recall or estimate height, or review the medical notes for recently recorded height.
- Factors affecting accuracy of height measure obtained e.g. curvature of spine should be documented.

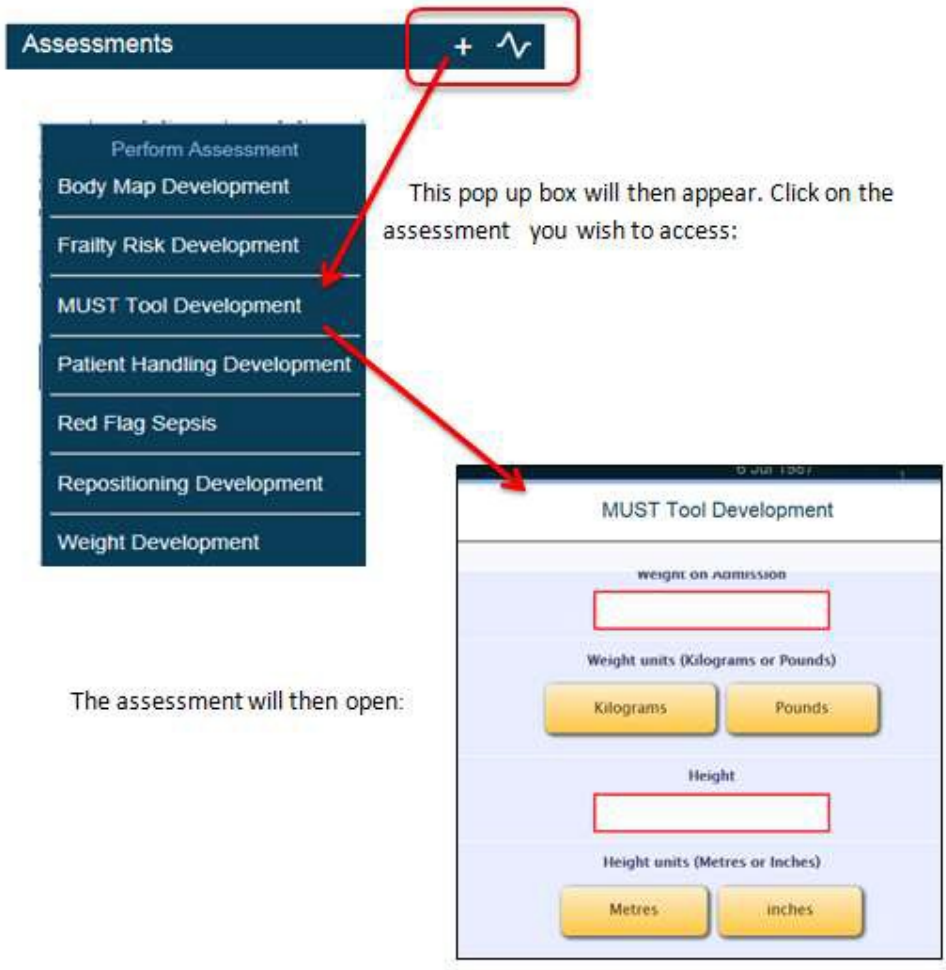
**C) Weight of patient 3-6 months ago.**

- Find out from patient, relatives, carers, medical notes, previous MUST calculations on nerve centre, care homes etc. patients weight 3 – 6 months ago
- If information on this cannot be gained, check for other clues such as loose fitting clothes or jewellery, reduced food intake or appetite, dysphagia problems, underlying disease or psychological/ physical problems likely to cause weight loss.
- Take particular care with patients who have abnormal fluid balance e.g. liver ascites or oedema as this could mask recent change in body weight. If there is visual evidence of loss of body fat or muscle score this.
- Document weight 3-6 months ago on MUST FORM (this will then be used to calculate % weight loss in step 6)

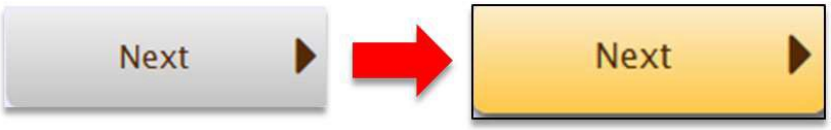
2. Access nerve centre to calculate MUST score:

   Via a desk top by
   Once you have logged into Nervecentre, click on Patient List in the top banner, choose your ward and double click on the name of the patient you wish to assess:

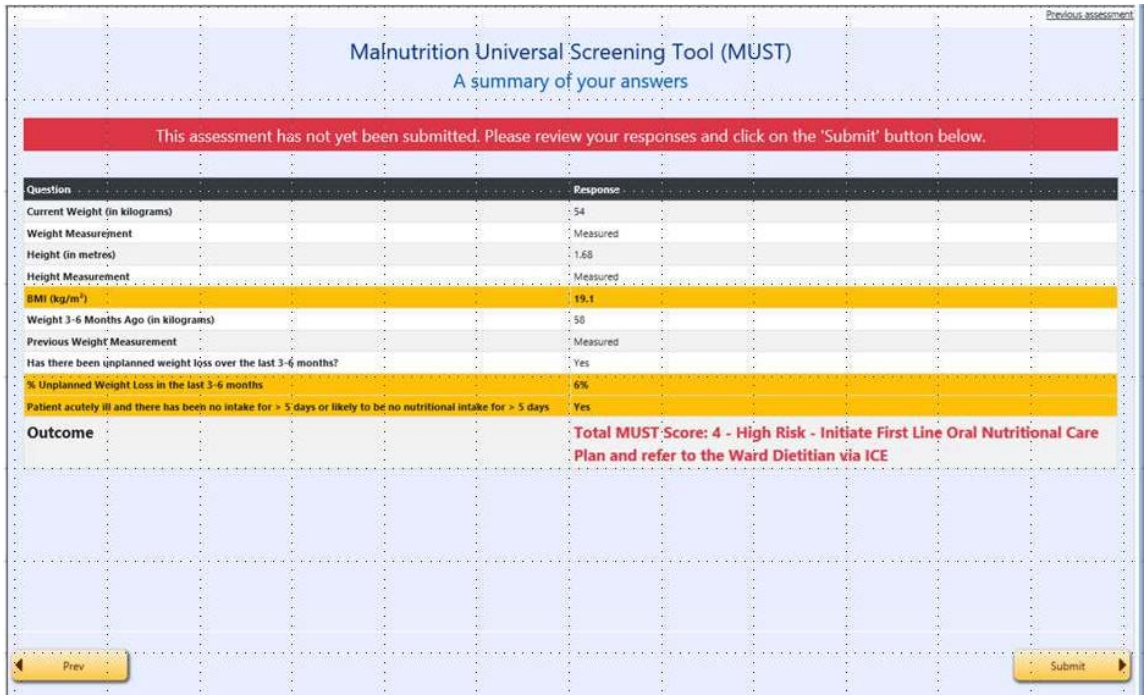
Click on the white cross on the Assessment banner, and select MUST:




Complete the assessment by clicking into each box and typing your response, or clicking on the relevant button. Your chosen option will be highlighted with a tick and change in colour. Unless you have completed all necessary fields or selected a response from the buttons provided, the **Next** button in the bottom right hand corner will remain greyed out. Once all fields are completed, the **Next** button becomes activated (turns pale yellow):

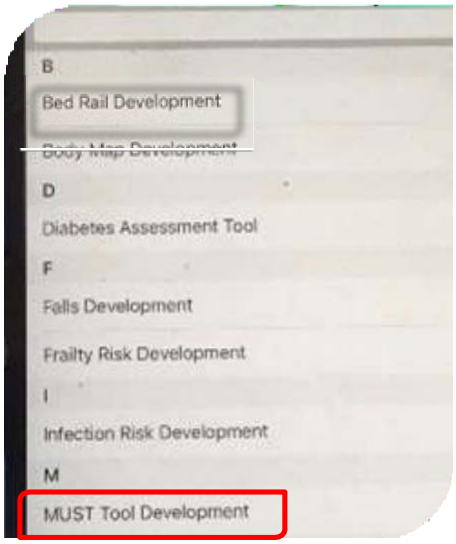


At the end of each assessment, you will be able to view a summary page of your answers. If you wish to amend your responses, then click on the **PREV** button until you reach the page you wish to amend. If you are happy with your responses, press the **SUBMIT** button:




Or via handheld device by:-
Once you have logged into Nervecentre, click on Patient you wish to assess and scroll down to the **assessment** which is below the observations

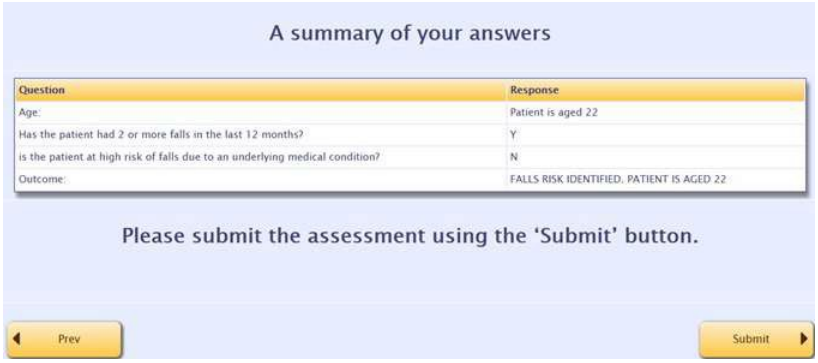

Click on **add assessment**, and then click the **assessment** that you want to complete




Complete the assessment by clicking into each box and typing your response, or clicking on the relevant button. Your chosen option will be highlighted with a tick and change in colour:


Unless you have completed all necessary fields or selected a response from the buttons provided, the **Next** button in the bottom right hand corner will remain greyed out. Once all fields are completed, the **Next** button becomes activated (turns pale yellow):


At the end of each assessment, you will be able to view a summary page of your answers. If you wish to amend your responses, then click on the **PREV** button until you reach the page you wish to amend. If you are happy with your responses, press the **SUBMIT** button:




3. During Nerve centre downtime calculate MUST score using following steps, on the form in appendix XX:

**Step One**: Calculate present **BMI** using measured weight and measured height

BMI can be calculated using the BMI chart
https://www.bapen.org.uk/pdfs/must/bmi-weight-loss-charts/must-table-up-to-100kg.pdf

or the following equation: **BMI = Present weight in kg ÷ Height in metres²**

Use the BMI calculated to get a 'MUST BMI score' - BMI Classification and MUST scores given in the table below:

| 'MUST BMI SCORE' | BMI (kg/m²) | Weight Category | Significance |
|---|---|---|---|
| 2 | <18.5 | Underweight | Poor protein –energy status probable. |
| 1 | 18.5 – 20 | Underweight | Poor protein- energy status possible. |
| 0 | 20.1 – 25 | Desirable weight | Poor protein – energy status unlikely. |
| 0 | >25 | Overweight | |

If the BMI is calculated from estimated body weight or height then validate against clinical observation

Remember if the patient presents with abnormal fluid balance e.g. oedema / ascites they are likely to have a raised body weight but this may be masking weight loss and they could be malnourished – if there is visual evidence of loss of body fat or muscle score 1 or 2.

**Step Two**: Weight loss using the weight they used to be 3-6 months ago and the present weight

Calculate using weight loss chart: https://www.bapen.org.uk/pdfs/must/bmi-weight-loss-charts/kg-only-30to169kg-previous.pdf

or by using the following equation:

% wt loss = old weight (weight used to be) – present weight x 100

Old weight (used to be)

Use the % weight loss calculated to get a 'MUST %weight loss score' Weight loss category and MUST score given in the table below:

| MUST % WEIGHT LOSS SCORE | Unplanned weight loss in the past 3-6 months (%) | Significance |
|---|---|---|
| 2 | > 10% | Clinically significant |
| 1 | 5 – 10 % | Early indicator or increased risk of under nutrition. |
| 0 | <5% | Within normal intra individual variation. |

If % weight loss has been obtained from an estimate, or you have been unable to quantify this, look for visual signs of weight loss and score 1-2 if appropriate. Evidence suggestive of weight loss would include:

- Clothes or jewellery have become loose fitting
- Does the patient report a history off decreased food intake, reduced appetite or dysphagia over 3-6 months.
- Underlying disease or psychological / physical disability likely to cause weight loss.
- If the patient presents with abnormal fluid balance this will mask any recent change in body weight and / or BMI. If there is visual evidence of loss of body fat or muscle - score 1- 2.

**Step Three**:- Calculate MUST Ac**ute Disease Score**.

If the patient has an acute illness **and** there has been no nutritional intake, or there is likely to be no nutritional intake for five days or more, they are likely to be at nutritional

risk and a score of 2 is given, such patients include those who are critically ill, have swallowing difficulties, brain injury or undergoing gastrointestinal surgery.

**Acute illness + No nutritional intake for five days or more = Score 2**

Patients should score either 0 or 2 for this section, score for no or virtually no intake during the 5 day period along with acute illness.

**Step Four** :- Establish overall risk of malnutrition by adding up the three scores

The chart below gives the classification of MUST scores:

| MUST SCORE | Malnutrition Risk |
|---|---|
| 0 | Low Risk |
| 1 | Medium Risk |
| 2 + | High Risk |

4. Use MUST score calculated via nerve centre or by hand to start a clear action plan:-
If indicated start a nutritional support care plan, and refer the patient to the ward dietitian for full nutritional assessment. Summary of expected action plans are given in the table below:

| MUST SCORE | ACTION |
|---|---|
| 0 | Low risk – repeat weekly |
| 1 | Medium risk – Start first line oral nutrition care plan, and review after 3 days. |
| 2 | High Risk – Start first line oral nutrition care plan, and review after 3 days. |
| 3 | High Risk – Start first line oral nutrition care plan, and review after 3 days. |
| 4 | REFER TO WARD DIETITAN, and start first line nutritional care plan |
| 5 | REFER TO WARD DIETITAN, and start first line nutritional care plan |
| 6 | REFER TO WARD DIETITAN, and start first line nutritional care plan |

It is important to also use your clinical judgement and a patient should be referred to the ward Dietitian if:

- They have a MUST score of 4 or more

- Enteral tube feeding is required
- NBM > 5 days
- MUST score increases
- There is no improvement on core care plan / first line nutritional care plan
- Specialist advice is required following diagnosis
- Patient requires a therapeutic diet, e.g. allergy, metabolic
- Weight drops 1kg/week.

Further details on 'nutritionally screening' and 'first line oral nutritional care' can be found in the trusts 'Nutritional Screening and First Line Oral Nutritional Care Policy for Adults'.

## Appendix 3: Manual MUST for when NerveCentre is on downtime or in the event of a IT major incident

Name: Hospital No:

### Malnutrition Universal Screening Tool (MUST)

(To be completed for inpatients staying more than 24 hours. Please circle where appropriate)

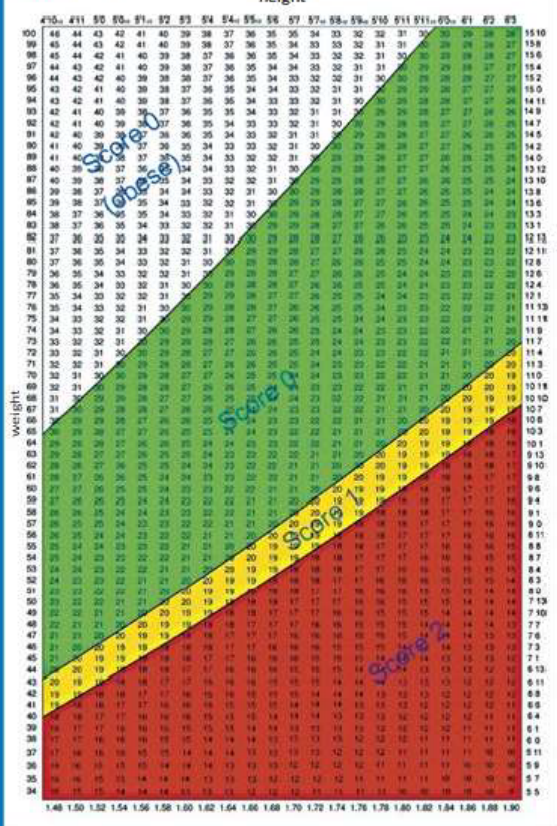
| Weight on Admission | Height | Body Mass Index (BMI) | Weight 3-6 months ago | % Weight Loss |
|---|---|---|---|---|
| kg<br>Measured / recalled | m<br>Measured / recalled | kg/m²<br>Use chart to calculate from current height and weight | kg<br>Measured / recalled<br>don't know | Has there been a change in weight over last 3-6 months?<br>Yes / No / Don't know<br>If Yes how much? |

### Malnutrition Universal Screening Tool (MUST) Score

(Please circle the score and ensure you use the current weight - this must be recorded on a weight chart)

| Date: | | | | | | |
|---|---|---|---|---|---|---|
| **A - BMI** | | | | | | |
| Less than 18.5 kg/m² | 2 | 2 | 2 | 2 | 2 | 2 |
| Between 18.5 kg/m² and 20 kg/m² | 1 | 1 | 1 | 1 | 1 | 1 |
| More than 20 kg/m² | 0 | 0 | 0 | 0 | 0 | 0 |
| **B - % unplanned weight loss over last 3-6 months?** | | | | | | |
| More than 10% | 2 | 2 | 2 | 2 | 2 | 2 |
| Between 5% and 10% | 1 | 1 | 1 | 1 | 1 | 1 |
| Less than 5% | 0 | 0 | 0 | 0 | 0 | 0 |
| **C - Acute Disease Effect Score** | | | | | | |
| Patient acutely ill and there has been no intake for >5 days or likely to be no nutritional intake for >5 days — Y | 2 | 2 | 2 | 2 | 2 | 2 |
| Patient acutely ill and there has been no intake for >5 days or likely to be no nutritional intake for >5 days — N | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Risk Score: | | | | | | |
| Assessing Nurse Signature: Print Name: | | | | | | |

**BMI Score**




Score 0 = Low Risk - reassess weekly or if condition changes

Score 1 = Medium Risk - initiate First Line Oral Nutrition Care Plan

Score 2 or more = High Risk - initiate First Line Oral Nutrition Care Plan, if no improvement or score 4 or more refer to Dietitian

**Repeat MUST Score weekly or if condition changes and complete on discharge. Use the latest patient weight**

| Date | Weight |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Appendix 4: First Line Oral Nutrition Care Plan

| Please Complete or Affix Identification Label | | | University Hospitals of Leicester NHS<br>NHS Trust |
|---|---|---|---|
| Surname | Forename | | |
| | | | |
| | | | |
| | | | |
| Hospital No | NHS No | | |
| | | | Moved to |
| Date of Birth | Ward | Site | Date and Time Moved |

### First Line Oral Nutrition Care Plan

**Goal: To monitor Patient's who score 1 or more on the MUST for signs of malnutrition and encourage fluid and diet intake**

**Actions / Care Need**

a) Assist patient with ordering suitable meal choices ( recommend high energy/high calorie main courses and puddings using the coding on the menu)

b) Ensure any special diet is ordered if required by using coding on the menu (e.g. non gluten containing ingredients or vegetarian, or via catering services (e.g. puree, peanut and tree nut free, low residue) and refer to the Ward Dietitian to order any exclusions (e.g. multiple allergies)
Details of diet required: .....

c) Offer assistance with eating and drinking at mealtimes and inbetween mealtimes, initiate red tray / red lid system if indicated as detailed in the Enhancing Patient Mealtimes Guidelines.

d) If patient has difficulties in swallowing refer to SALT for assessment, Date referred.....

e) Encourage the patients to request additional items for snacks between meals

f) Encourage the patient to drink milk and milky drinks

g) Offer patient one build up a day (no need to be prescribed) unless contraindicated e.g. patients with renal disease, lactose intolerant, milk allergy or patient following a low residue diet. Contact Ward Dietician for advice.

h) Treat underlying conditions that may prevent eating and drinking such as nausea, vomiting, diarrhoea

i) Commence food intake charts for all meals, snacks and record an accurate fluid balance

j) Weigh the patient twice a week and document on weight chart.

k) Review three days after initiating care plan and if intake is poor / minimal refer patient to Ward Dietitian

Other care needs (please state):

| Name of Nurse | Signature | Date |
|---|---|---|
| | | |

**First Review (3 days after initiating care plan)**

On evaluation of food charts for past three days does patient require referral to Ward Dietitian? Yes / No

**If Yes:** Continue food charts and this care plan
Date referred to Ward Dietitian in ICM.....

**If No:** Continue to nutritionally screen using MUST once a week after admission and continue to monitor using the Nutrition Core Care Plan

Any other comments:

| Name of Nurse | Signature | Date |
|---|---|---|
| | | |

**Further reviews**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Date Reviewed:** | | | | | | | | | | |
| **Care Plan Active?** | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| ***Print Name*** | | | | | | | | | | |

SR0017 lgdi

# First Line Nutritional Advice

**The Malnutrition Universal Screening Tool 'MUST' should be completed on admission for all adult in-patients, and repeated weekly (if clinical condition changes and on discharge).**
**A 'first line oral nutrition care plan' should be commenced for patients with a MUST score of ≥ 1 implement the measures below:**

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

Make sure your patients have an appropriate **menu** to choose their meals from (paper menus are available from catering).

Help patients make suitable choices from the menu, **high energy options** are highlighted by or . The new 'smaller energy dense meals' can be useful

Encourage **milky drinks***


Offer 1 **Aymes shake*** drink a day (no need to prescribe). Shakes and soups ordered from catering. Consider 'Aymes - rounds'.

Little and often: use **snacks** between meals. Snacks are available **3 times a day** (offer with tea/coffee rounds). Full snack menus available from catering and in catering folder)

**Assist** and **encourage**

Use the **red tray** system indicated by RT behind bed

Use the **meal planner** form if choice is difficult to communicate


Monitor progress:

- **Twice weekly weights**
- Complete **food record charts**, for all meals, snack, drinks & nutritional supplements

**Review intake after 3 days, if intake remains minimal, refer to your ward dietitian.**

**Treat underlying conditions** that may prevent eating e.g. nausea, vomiting, diarrhoea

***Exceptions**: *Patients with renal disease, lactose intolerance, metabolic or milk allergy should not be offered milk based fluids (including Aymes supplements). Liaise with your ward Dietitian for further advice in these instances. All other aspects of the first line nutritional support advice are relevant to most patients.*



One team shared values

## Appendix 6 : Procedure for documentation and clinical monitoring of food and fluid intake

The documentation of food and fluid intake is an important part of nutritional screening. It allows us to estimate whether the patient is getting enough energy, protein, vitamins and minerals. A registered nurse must be able to make a judgement based on what is documented to assess if a patient needs referral for a full nutritional assessment by the ward Dietitian, or if measures at ward level need to be taken to supplement what is being eaten. It is therefore very important that what is documented is a true reflection of the patient's nutritional intake.

A Dietitian may request that food record charts are kept once a patient is referred to them, to assess the effectiveness of the measures they have suggested. In this case it is the Dietician's responsibility to review the food charts, and comments on the adequacy of the intake can be made in the nutritional assessment column of the form.

Documentation should be undertaken as per the UHL Documentation Policy DMS Number B30/2006.

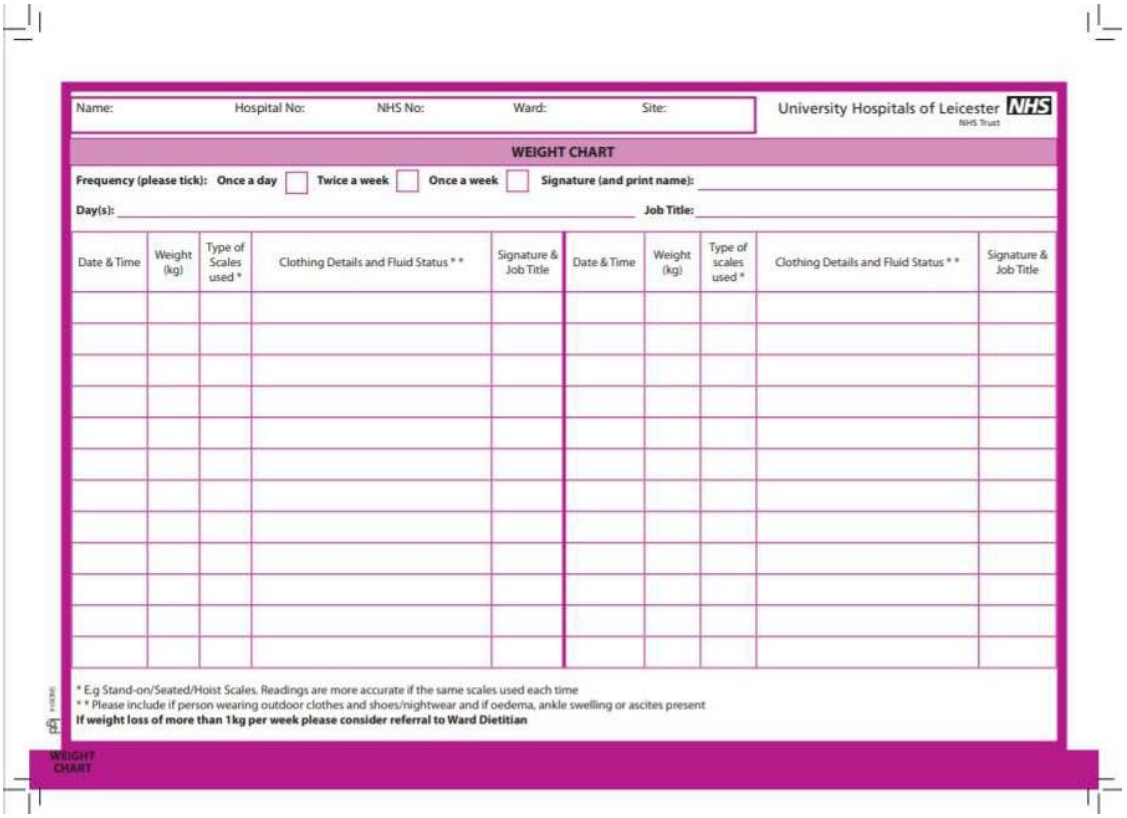
Progress against the nutrition support care plan should be monitored closely. Undertake observations to assess whether the patient's appetite, food intake and weight are improving or deteriorating. Use the following methods and tools:-

- Document and set out nutritional care on Care Plan.
- Repeat body weight measurements twice weekly for inpatients. Record on body weight chart – Standard nursing documentation. See Appendix 7.
- Repeat MUST weekly for inpatients – Standard nursing documentation. See Appendix 1.
- Commence food intake charts for all meals and snacks on MUST tool and continuation charts. See Appendix 8.
- Review intake after three days. If intake remains poor refer to ward Dietitian.
- Fluid Balance Chart (if indicated)

| **Who should document food / fluid intake** | |
|---|---|
| 1.1 | ▪ Anyone who gives food out to a patient, takes away the used trays, observes eating or helps with feeding should document the intake on the food chart.<br>▪ It is the responsibility of the nursing staff to ensure the food record chart is completed, but it could be; the patient, staff nurse, nursing support staff, housekeeper, domestic staff, mealtime volunteers, student nurses, relative (if happy to do this), or allied health professional if appropriate, that document information on the chart. Where appropriate the patient should be encouraged to complete the chart themselves. |
| **What needs to be documented** | |
| 1.2 | ▪ All food and fluid offered to the patient needs to be documented on the food chart and the food consumed needs to be recorded. See food chart as part of MUST tool and continuation sheets – Standard nursing documentation. See Appendix 8. This includes all food from hospital menu, better hospital food snacks, extra food provision from patient locker, food and drinks from visitors, restaurant food and drinks, all drinks including supplements, Aymes Shakes, milky drinks. |

| How to document food intake | |
|---|---|
| 1.3 | ▪ As much information as possible should be included about the type and quantity consumed.<br><br>Under 'Description'<br>▪ List each food given in the meal, for example; Weetabix, cornflakes (not just 'cereals').<br>▪ Include the name of the dish ordered from menu for each course e.g. Shepherd's pie, potatoes, peas, gravy and rice pudding - standard (not just 'main meal' or 'pudding').<br>▪ If the food comes in different forms document the exact type e.g. full fat yogurt or diet yogurt, HP or standard milk pudding, standard or HP Soup, or Aymes Shakes, Soups or Smoothies, full fat milk, semi-skimmed or skimmed.<br><br>Under 'amount consumed'<br>▪ Write the amount eaten e.g. '2 biscuits' next to Weetabix, '½ bowl' next to cornflakes.<br>▪ It is more useful to document amount consumed as ¼, ½ or ¾ of a plateful rather than 20 spoonfuls as this is difficult to visualise. If the patient eats less than ¼ of a plateful, then you can document as spoonfuls. |
| **How to document fluid intake** | |
| 1.4 | ▪ Document all fluids consumed in mls on the food record chart. The quantity is important to assess the contribution to energy and protein intake<br>▪ It may also be necessary to record the volume taken on a fluid balance chart. In certain situations (such as renal patients on fluid restrictions) it may be necessary to record the volume of liquid food items on the fluid chart<br>▪ Standard drinks contain:<br>• A standard hospital white plastic cup (used for hot drinks) provides 200 mls<br>• A standard clear plastic glass contains 200 mls<br>• A prescribed supplement in a plastic bottle e.g. Fortisip, Fortijuce contains 200 mls. |
| **A guide to what is adequate / not adequate** | |
| 1.5 | ▪ Food record charts should be kept for 3 days and then reviewed by the registered nurse looking after the patient.<br>▪ Patients should eat foods from each of the food groups over the course of the day.<br>▪ Patients consuming less than ¾ of all food offered to them will require additional snacks and milky drinks.<br>▪ Patients consuming less than half of all food offered to them at mealtimes (main course and pudding) and not taking additional milky drinks or snacks are unlikely to be meeting their requirements and should be referred on for dietetic assessment.<br>▪ If a patient does not regularly consume any main course they are unlikely to be meeting their nutritional requirements.<br>▪ This needs to be in-conjunction with weight monitoring and clinical judgment. |

## Appendix 7: BODY WEIGHT CHART



Name: Hospital No: NHS No: Ward: Site:

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**WEIGHT CHART**

**Frequency (please tick):** **Once a day** ☐ **Twice a week** ☐ **Once a week** ☐ **Signature (and print name):** _____

**Day(s):** _____ **Job Title:** _____

| Date & Time | Weight (kg) | Type of Scales used * | Clothing Details and Fluid Status * * | Signature & Job Title | Date & Time | Weight (kg) | Type of scales used * | Clothing Details and Fluid Status * * | Signature & Job Title |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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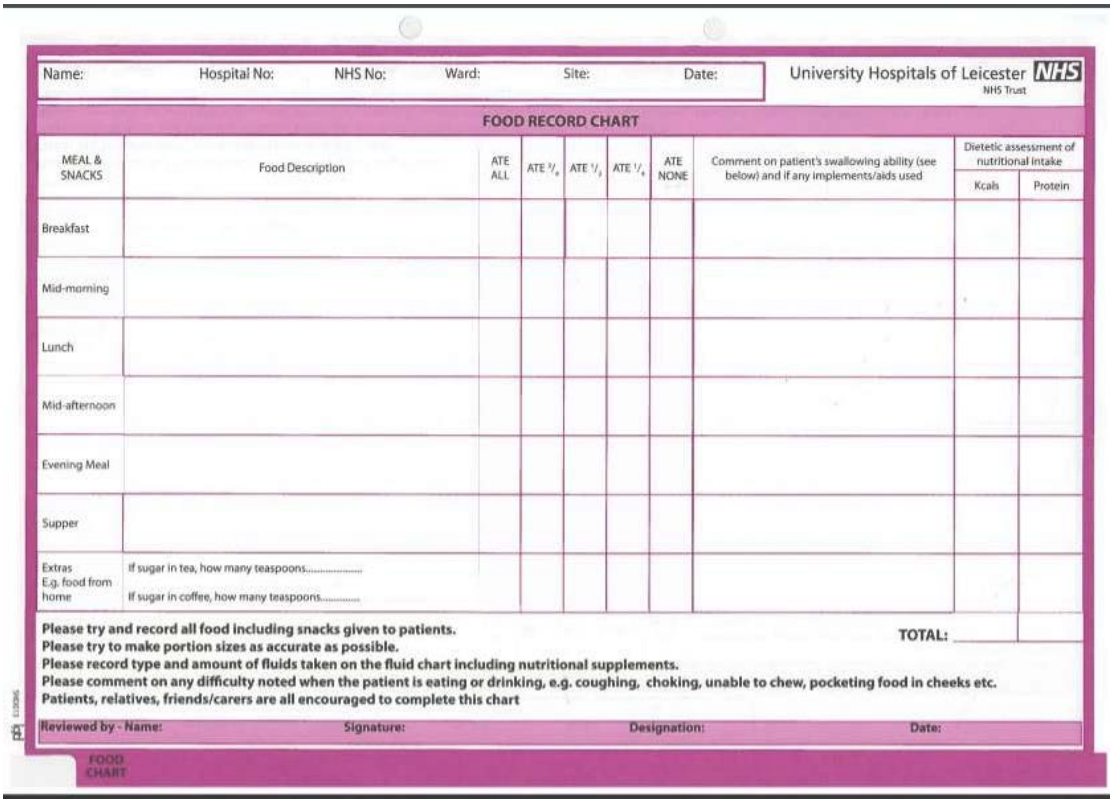
* E.g Stand-on/Seated/Hoist Scales. Readings are more accurate if the same scales used each time

* * Please include if person wearing outdoor clothes and shoes/nightwear and if oedema, ankle swelling or ascites present

**If weight loss of more than 1kg per week please consider referral to Ward Dietitian**

WEIGHT CHART

## Appendix 8: FOOD RECORD CHART



Name: Hospital No: NHS No: Ward: Site: Date:

University Hospitals of Leicester NHS
NHS Trust

**FOOD RECORD CHART**

| MEAL & SNACKS | Food Description | ATE ALL | ATE ¾ | ATE ½ | ATE ¼ | ATE NONE | Comment on patient's swallowing ability (see below) and if any implements/aids used | Dietetic assessment of nutritional intake | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Kcals | Protein |
| Breakfast | | | | | | | | | |
| Mid-morning | | | | | | | | | |
| Lunch | | | | | | | | | |
| Mid-afternoon | | | | | | | | | |
| Evening Meal | | | | | | | | | |
| Supper | | | | | | | | | |
| Extras E.g. food from home | If sugar in tea, how many teaspoons.....<br>If sugar in coffee, how many teaspoons..... | | | | | | | | |

**Please try and record all food including snacks given to patients.**
**Please try to make portion sizes as accurate as possible.**
**Please record type and amount of fluids taken on the fluid chart including nutritional supplements.**
**Please comment on any difficulty noted when the patient is eating or drinking, e.g. coughing, choking, unable to chew, pocketing food in cheeks etc.**
**Patients, relatives, friends/carers are all encouraged to complete this chart**

**TOTAL:**

**Reviewed by - Name: Signature: Designation: Date:**

FOOD CHART