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Use of the malnutrition universal screening tool (MUST) within hospital and community care home environments in Norfolk

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Malnutrition is a common under-recognised problem with medical and economic implications. Estimates of malnutrition range from 28% in hospitals to 65% in care homes[(1)]. MUST is a validated reproducible protocol for identifying patients at risk of malnutrition developed by the Malnutrition Advisory Group of the British Association for Parenteral and Enteral Nutrition. Despite national guidance stating that nutritional screening should occur routinely, such methods are not being used regularly[(2)]. The present study assessed whether all patients undergo adequate nutritional screening using MUST in concordance with National Institute for Health and Clinical Excellence (NICE) guidelines[(3)]. A single time-point prevalence survey was conducted in two teaching hospitals and six community care homes. The completion of MUST assessments, use of surrogate measures and adequacy of follow-up were assessed if MUST was used.

	Individuals screened using MUST		Individuals screened using an alternative tool		Individuals not screened	
Location	%	95% CI	%	95% CI	%	95% CI
Hospital 1 (*n* 209)	0		32.5	28.4, 36.5	67.0	62.9, 71.1
Hospital 2 (*n* 123)	41.5	37.2, 45.7	31.7	27.7, 35.7	25.2	21.4, 29.0
Care homes (*n* 197)	71.6	67.7, 75.5	10.6	8.0, 13.4	17.8	14.5, 21.1
Total (*n* 529)	36.3	32.1, 40.5	24.2	20.5, 27.9	38.9	34.7, 43.2

Three patients were in the environments but had arrived so recently that screening was not practicable.

Nutritional screening was assessed in 529 patients. The median age of subjects was 80 (range 17–106) years. The study found that malnutrition screening in Norfolk failed to meet NICE guidance. Care homes performed nutritional screening to a higher standard than hospitals. MUST assessments were often incomplete; 27.6% of stage 2 and 28.1% of stage 3 scores were not recorded, meaning that the malnutrition risk scores were inaccurate. Rates of medium or high risk of malnutrition ranged from 27.6% to 33.3%. Over 90% of these patients received appropriate follow-up according to local protocols. Many potential reasons were identified for poor nutritional screening, including lack of equipment and differences in training. To improve nutritional screening, designated time should be allocated to complete MUST. Adequate equipment must be provided including compact MUST *pro forma* in patient admission booklets and explanatory posters. Training should focus on the importance of screening and specific instruction on stages 2 and 3 of the MUST form. Nutritional screening in the sampled clinical environments should be re-assessed in 1 year.

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