**GUIDANCE NOTES FOR THE USE OF GG&C MUST STEP 5:**

**NUTRITIONAL MANAGEMENT PLAN FOR CARE HOME STAFF**

## When to Use:

The MUST Step 5 document should be completed by a qualified member of staff for any resident scoring a MUST 1 or above. It will provide evidence that you have highlighted that this resident is at nutritional risk and what your nutritional action plan will be.

## Filling out the Form:

Complete resident demographics then sign your name and designation in the "Assessed by" box.

Note "Activity Levels" will range from "bedbound/immobile" to "highly active" for those who continuously pace. This will help to highlight any changes in energy expenditure and possible reasons for weight loss.

Please ensure you take into account whether the resident has any visible oedema or ascites as this will affect weight recordings. Correcting a resident's weight by using the table below will allow a more accurate guide to current BMI as well as percentage weight loss:

| Guide for assessing average weight of: | Ascites | Oedema |
|---|---|---|
| Minimal | 2.2kg | 1.0kg |
| Moderate | 6.0kg | 5.0kg |
| Severe | 14.0kg | 10.0kg |

***Ref: - The Parenteral and Enteral Nutrition Group – Pocket Guide to Clinical Nutrition***

Initially, detailed food and fluid charts should be recorded for **3 days** and **assessed** prior to completing Section 1 of the document if this is a new resident to the home. This will enable staff to gain an idea of any changes to nutritional intake and identify any common themes, e.g frequent food refusal, texture difficulties, time of day for optimal intake.

Ensure all dietary needs, including physical and environmental, are being met and that alternative options are available if required e.g texture modified snacks, finger foods, etc. Also ensure all food and fluid offered reflects resident's recorded likes and dislikes.

## Section 1: Problems Affecting Nutritional Status

From a combination of your clinical assessment of the resident and the results of the food and fluid records you should now be able to circle whether any of the factors listed in the table have been affecting their ability to eat and drink and/or nutritional status. If you have circled "yes" please indicate what **action** you have or will put in place for each.

For example:

a) Swallowing difficulties – consider referral to Speech and Language Therapy

b) Dental problems – encourage improved oral hygiene, consider referral to Community Dentist

c) Postural problems/requires support – ensure food/fluid easily ,consider finger foods

use small eating and drinking aids, consider referral to Community Physiotherapist and/or Occupational Therapist

d) Recent acute medical issues – this could include infection (urine/chest), vomiting and/or diarrhoea, constipation, fracture/falls, pressure sores, oedema or nausea, all of which could have resulted in a recent hospital admission, liaise with GP and review medications.

e) Mental health issues/challenging behaviour – liaise with GP and review, consider referral to Community Psychiatric Nurse (CPN).

**MUST Step 5 should be discontinued when a resident is approaching end of life and MUST Step 5 has been deemed to no longer be of benefit to that individual.**

**If disease progression is recognised as the likely cause of increased nutritional risk, discuss with the resident's GP whether nutritional intervention remains appropriate. It may be that no benefit is seen from nutritional support and/or could be detrimental to the resident. If agreed with the wider MDT that nutritional intervention is not appropriate, tick the box and sign. There is no need to fill out the rest of the form and the MUST step 5 can be discontinued. Ensure this is communicated to the resident if possible, loved ones and the wider team.**

**Please refer to 'NHS GGC Guidance at end of life' link** Guidance At End Of Life (GAEL) for Health Care Professionals (543) | Right Decisions

## Section 2: Establish Nutritional Aims

You now need to think about what you would like to achieve with nutritional intervention. Read the 4 options and choose the most suitable for your resident (this could be more than 1 option). Please note that option 1 and option 2 contradict each other so should not be selected at the same time. If a resident has recent weight loss with a low BMI you could select option 1 and then once weight has increased to recent weight this could be changed to option 2 weight maintenance as the BMI will not return to a healthy range. Options can be changed at each 4 week review as necessary.

### 1) Promote weight gain back to healthy BMI range

This would be if your resident had previously sat within the healthy BMI category and recenty lost weight, you would want to aim to regain weight back to within healthy parameters. If your resident was in the overweight category previously then had lost weight, you would want to promote weight gain within the healthy BMI range and not necessarily back to their previous weight.

### 2) Maintain current weight/nutritional status

This would be if your resident was of a low BMI but had maintained their weight and nutritional status for 6 months or more.

### 3) Optimise nutrient intake during period of illness

This would be if your resident is unwell and oral dietary intake is reduced, resulting in nutritional requirements not being met. This can be achieved through food fortification (see section 3)

### 4) Increase and promote adequate fluid intake

This would be if your resident's fluid intake had reduced and failing to meet daily targets. It could also be if fluid losses are apparent, for example through diarrhoea and vomiting, large volumes of wound exudate, or increased perspiration due to fever/environment.

All residents should be offered at least 10 cups (150mls) of fluid per day. If resident's are struggling with this volume or additional fluid is required, try encouraging jelly/ice-lollies/etc which can also contribute to fluid intake.

Once you have established your aim(s), sign and date beside your chosen option(s) and move on to section 3.

## Section 3: Commence Food Fortification for 4 Weeks

First line dietary interventions should be implemented at this point. These include offering 3 energy dense meals per day (small portions may be indicated if the resident has a poor appetite) and up to 3 nourishing snacks per day. Remember to have texture modified options available for those that require them. Also, take into account your resident's likes and dislikes.

The table provides examples of food fortification methods that can be used to increase the energy content of meals/snacks. Please try to incorporate options with a maximum of 3 options at a time which would work giving an extra 600 calories oer day as indicated on the MUST Step 5 form.

If you have a resident with diabetes requiring food first, try to avoid the options of adding extra sugar/jam/honey to drinks and puddings as this would not be suitable.

Any changes to your resident's dietary requirements should be shared with the kitchen and all resident documentation should be updated.

For futher guidance on food fortification please refer to your MUST reference folder

**Food and fluid charts should be kept during this 4 week period for further assessment and to provide evidence that first line interventions have been implemented**

## Progress Chart

After the initial 4 week period you now want to assess whether first line intervention has been sucessful. Document the date of your review then refer back to your original aim(s) and tick whether this has been met, partially met or not met.

For example, if your aim was to promote weight gain back to healthy BMI range and this had been achieved, you would tick the “Aim(s) fully met” box and document your explanation and action taken. Your explanation could be “Food fortification sucessful, BMI now stable at 21”. Action taken could be “Continue first line dietary interventions. If weight increases further discontinue and offer normal diet” There would now be no need to carry on filling out the rest of the form.

If the resident’s weight had started to increase but had not quite reached the healthy BMI range yet, you would tick the “Aim(s) partially met” box. Your explanation could be “Slight weight gain however BMI remains low at 17.5, oral dietary intake marginally improved, dislikes cream but taking fortified milk well.” Your action taken could be “Continue first line interventions including food and fluid charts and review in 4 weeks.”

If no progress had been made e.g the resident’s weight continued to drop, you would tick the “Aim(s) not met” box. Your explanation could be “Further weight loss, no improvement in oral intake which remains poor, dislikes fortified milk” At this point you know first line intervention has been unsuccessful and your action taken would then be to contact your relevant health care professional for further advice.

In the next box please record who you have contacted, the date contact was made, then sign and document your profession.

## Contacting Your Relevant Health Care Professional

For Care Homes Within  Greater Glasgow NHS area please refer also to your existing Care Pathway poster. It helps to work with these guidance notes to give better clarity to decision making. Your initial HealthCare Professional after 4 weeks will be your Care Home Liaison Nurse. She/He will provide you initial support to maximise oral dietary intake and review the MUST Step 5 to review if anything else could be tried in section 1 or 3.

At the 8 week review if nutrition goals are still not met, a referral should be initiated to the Community Dietetic contact along with a copy of the MUST Step 5 documentation for that resident.

**Oral Nutritional Supplement (ONS) Monitoring Form**

Monitoring of ONS is essential to ensure they are effective and residents are managing to take them as prescribed.

When completing the monitoring form always document the following:-

- The correct product and daily dose including any specific instructions on when or how to give the products as per the Dietitian's instructions
- Any issues with tolerance or likes and dislikes with the ONS (if residents are not taking the full dose or refusing ONS always report this to the Dietitian supporting the clinical caseload in that home.
- In the actions required box try to document the reasons for continuing ONS e.g. continued weight loss, swallowing difficulties
- When any changes are made to product or dose and when they are discontinued

Please stock check before ordering supplements as this reduces wastage and avoids stockpiling of ONS.

If you feel a resident no longer requires their supplements or could reduce their dose please discuss with Community Dietitian.