

Malnutrition Matters, Joint BAPEN and Nutrition Society Meeting, 27–28 November 2007

Implementing MUST – not as easy as it should be

A. Beazley, A. Eeles, J. Friend, E. Walters and M. Stroud

Institute of Human Nutrition and Southampton University Hospitals Trust, Southampton General Hospital, Tremona Road, Southampton SO16 6YD

In early 2006, our hospital adopted the National Institute for Health and Clinical Excellence (NICE) Nutrition Support guidelines' recommendation that all patients should be screened using the Malnutrition Universal Screening Tool (MUST) on admission and weekly thereafter. Measures to ensure that ward areas were aware of the policy included a formal launch, information on our intranet, senior nurse briefings and ward-based dietitian teaching. Each ward also identified a nutrition liaison nurse who attended three specific training days. Despite these measures, it became clear that implementation of the policy was limited and we therefore carried out an audit of MUST screening rates and an enquiry into nurses' knowledge and attitudes towards MUST.

Medical, nursing and 'bed-end' notes were used to identify percentage of patients screened using MUST on a medical (M), a surgical (S) and an elderly care (EC) ward. Each ward audit was performed on 1 d with same-day screening of all ward patients by the audit team. Since very few patients on the three wards had actually been screened, adherence to the Trust 'linked nutritional care pathways' for patients identified as 'at risk' was assessed in a wider notes audit of twelve wards. Questionnaires were also given to fifty-nine nursing staff in M, S and EC to determine attitudes to MUST and their perceptions of barriers to implementation.

In the three-ward survey, only 14% of patients had been MUST screened on admission, with 31% screened within 7 d (16% M, 20% S, 61% EC) and just six identified as at risk. On the same wards, the audit team screened seventy-one patients of whom (n 31 (44%)) were at nutritional risk. A total of 81% of patients at risk had therefore been missed by ward staff. Nutritional documentation was missing from 56% of notes and, where present, was incomplete in 50%. Admission screening rates were also just 14% in the wider twelve-ward survey, leading to thirty-six patients identified as at nutritional risk. Of these only fifteen (42%) were on their complete care pathway.

Most nurses felt that MUST was important: medians 8.4 M, 8.4 S, 9.3 EC (where 10=most important, 0=unimportant) and 76% believed that 'all or most' patients on their ward were routinely screened. However, they were less confident that MUST justified the time involved in their patients: medians 5.4 M, 5.3 S, 8.3 EC, range 0–10 (10=strongly agree time-justified, 0=strongly disagree). Most nurses cited lack of time as the principal constraint to MUST screening: median 8.0 all settings (10=strongly agree time a constraint) although there were also problems with access to measuring equipment especially stadiometers. Despite the Trust initiatives, 66% of nurses had not attended formal MUST training and these individuals were less likely to value its importance compared with those who had been formally trained: medians 6.7 v. 3.2 M, 6.1 v. 3.5 S, 8.6 v. 7.8 EC, 7.6 v. 5.5 all settings ($P=0.031$) (10=strong agreement time-justified).

Hospital policy to adopt MUST screening and associated nutritional care plans care has failed yet staff are unaware of the failure. It seems likely that MUST can only be implemented if formal training is made compulsory and additional resources such as nutrition care assistants may be required.