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Uptake of the MUST screening tool for inpatients in a Teaching Hospital: an audit of progress to date

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The Malnutrition Universal Screening Tool (MUST) has been designed to help identify adults who are malnourished or at risk of developing malnutrition. Effective identification and nutritional intervention is known to improve clinical outcomes for patients[1]. The patient population admitted to the teaching hospital is drawn from a local area of high socioeconomic deprivation; therefore effective screening and intervention needs be a priority for the organisation.

MUST was introduced across the Trust in July 2006. Screening should be completed within 24 h of admission, as recommended by National Institute of Clinical Excellence[2]. The Electronic Patient record was audited in April 2007, (see cycle 1 in the Table). At the time these results compared unfavourably with completion of Waterlow Scores (57 % completed within 24 h, 87 % during their hospital admission. Given the initial audit results, MUST was launched as a Key Performance Indicator (KPI) with the support of hospital matrons and ward managers. A repeat audit was then undertaken after 3 months (see cycle 2 in the Table).

	Cycle 1			Cycle 2		
	MUST scored <24 h (%)	MUST scored during admission (%)	High MUST score (%)	MUST scored <24 h (%)	MUST scored during admission (%)	High MUST score (%)
All patient areas	39	74	23	45	79	17
Adult medicine	31	77	18	43	80	27
Elderly medicine	44	94	27	55	98	22
General surgery	60	87	16	70	83	23
Trauma and orthopaedics	51	66	0	60	78	4
Neurology/neurosurgery	14	38	11	23	52	12
Dermatology	67	100	11	65	95	0
Other	42	75	27	41	83	18

Although completion of MUST improved across the Trust, this was only marginal from 39 % to 45 % within the desired 24 h of admission. Although 79 % of patients were screened at some point during admission, this delay may have an adverse clinical impact on outcomes in acutely unwell, trauma and preoperative patients. Elderly medicine, general surgery and the regional dermatology service were most thorough in their compliance with screening. A detailed analysis is now required to understand the demographics and diagnostic categories of the patients not screened, and to address the reasons for non-compliance. Clearly there is scope for improvement; this will be co-ordinated by the nutrition steering group for the organisation.

1. Stratton RJ *et al.* (2004) *Br J Nutr* **92**, 799–808.
2. NICE (2006) *Nutrition Support in adults: oral supplements, enteral tube feeding and parenteral feeding*. Guideline 32 London: Department of Health.