STEP 5 – MANAGEMENT GUIDELINES
Use this LOCAL COMMUNITY ACTION PLAN to develop care planning

Low risk – score 0	Medium risk – score 1	High risk – score 2 or greater
Routine clinical care	**Observe**	**Treat**
Weigh and repeat 'MUST' screening **Monthly in Care Homes** AND **Annually in Community (those living in own homes)** or sooner if clinical condition changes.	1. Document **food and drink*** intake for 3 days. 2. **Encourage** with eating and drinking. Provide assistance where necessary. 3. Implement a **FOOD FIRST*** approach and encourage with **HOMEMADE NOURISHING DRINKS*** (Aim for an extra 400-600 kcals daily) 4. Provide individual or family with The British Dietetic Association Food Fact sheet- **'Malnutrition'*** 5. Weigh and repeat 'MUST' screening **Every 2 weeks in Care Homes** AND **Every 4-12 weeks in Community** or sooner if clinical condition changes. 6. **Document** Weight, BMI, 'MUST' score, Action taken, Review date and Sign.	5. Weigh and repeat 'MUST' screening **Weekly in Care Homes** AND **Monthly in Community.** 7. **If no improvement after 4 weeks** obtain individuals consent and **REFER*** to the Community Dietetic Department or your local neighbourhood Team. **Do not refer if detrimental or No benefit from nutritional support is expected e.g. in the event of End of Life care or long term low BMI with no weight loss.**

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***Please see Resources**