

# Malnutrition Screening Tool (MST)

The MST is intended for use by volunteers or staff caring for older people. Please contact us if you require assistance using this document.

## Obtain consent to complete this screening by asking

‘Can I ask you some questions about your nutritional health?’

<p><b>Applies to the last 6 months</b></p>	<p><b>1. Have you / the client lost weight recently without trying?</b></p> <p>NO ..... 0</p> <p>UNSURE ..... 2</p> <p>YES, how much (kg)?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">1 – 5</td> <td style="width: 40%;">(2 – 13 lbs)</td> <td style="width: 30%; text-align: right;">1</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>6 – 10</td> <td>(14 – 23 lbs)</td> <td style="text-align: right;">2</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>11 – 15</td> <td>(24 – 33lbs)</td> <td style="text-align: right;">3</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>&gt;15</td> <td>(&gt; 33 lbs)</td> <td style="text-align: right;">4</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>.....</td> </tr> <tr> <td>Unsure</td> <td></td> <td style="text-align: right;">2</td> </tr> <tr> <td>.....</td> <td></td> <td>.....</td> </tr> </table>	1 – 5	(2 – 13 lbs)	1	.....	.....	.....	6 – 10	(14 – 23 lbs)	2	.....	.....	.....	11 – 15	(24 – 33lbs)	3	.....	.....	.....	>15	(> 33 lbs)	4	.....	.....	.....	Unsure		2	.....		.....	<p><b>If unsure, ask if they suspect they have lost weight e.g. clothes are looser</b></p>
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<p><b>For example less than ¾ of usual intake</b></p>	<p><b>2. Have you / the client been eating poorly because of a decreased appetite?</b></p> <p>NO ..... 0</p> <p>YES ..... 1</p>	<p><b>May also be eating poorly due to chewing or swallowing difficulties</b></p>																														
<p><b>Total of weight loss and appetite questions</b></p>	<p>_____</p> <p><b>Total Score:</b></p>																															

Adapted from: ‘Malnutrition – Is your patient at risk?’ Screening Tool and Action Flowchart, Merylyn Banks APD, Ferguson M, et al. *Nutrition* 1999, 15; 458- 464.

## Scoring

- **A score of 0-1** means the client is at low risk of malnutrition. Review every six to 12 months.
- **A score of 2** means the client may be at risk of malnutrition. Use the 'Nutrition Risk Identification Questions' to identify any issues that might be contributing. Find and use strategies to support clients to deal with any issues that you identify. Review in two to three months.
- **A score of 3-5** means the client is at high risk of malnutrition. Use the 'Nutrition Risk Identification Questions' to identify any issues that might be contributing. Find strategies to support clients to deal with any issues that you identify.
- Refer to a doctor or an Accredited Practising Dietitian promptly if weight and/or food intake does not improve quickly, following efforts to address identified issues.

## Key points to remember

- Malnutrition is preventable and reversible.
- Consistent gradual weight loss can add up to significant weight loss and malnutrition over time.
- Overweight/obese clients who have unexplained weight loss or decreased appetite can be at risk of malnutrition too.
- After you assess that a client is at risk, it is important to identify what may be contributing to this risk, and to take action quickly.
- This screening tool identifies those at risk of malnutrition but is not intended to be used to diagnose malnutrition. This can be done by an Accredited Practising Dietitian.