‘Malnutrition Universal Screening Tool’ predicts mortality and length of hospital stay in acutely ill elderly

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Malnutrition and its impact on clinical outcome may be underestimated in hospitalised elderly as many screening procedures require measurements of weight and height that cannot often be undertaken in sick elderly patients. The ‘Malnutrition Universal Screening Tool’ (‘MUST’) has been developed to screen all adults, even if weight and/or height cannot be measured, enabling more complete information on malnutrition prevalence and its impact on clinical outcome to be obtained. In the present study, 150 consecutively admitted elderly patients (age 85 (SD 5·5) years) were recruited prospectively, screened with ‘MUST’ and clinical outcome recorded. Although only 56 % of patients could be weighed, all (n 150) could be screened with ‘MUST’: 58 % were at malnutrition risk and these individuals had greater mortality (in-hospital and post-discharge, \( P<0·01 \)) and longer hospital stays (\( P=0·02 \)) than those at low risk. Both ‘MUST’ categorisation and component scores (BMI, weight loss, acute disease) were significantly related to mortality (\( P<0·03 \)). Those patients with no measured or recalled weight (‘MUST’ subjective criteria used) had a greater risk of malnutrition (\( P=0·01 \)) and a poorer clinical outcome (\( P<0·002 \)) than those who could be weighed and, within both groups, clinical outcome was worse in those at risk of malnutrition. The present study suggests that ‘MUST’ predicts clinical outcome in hospitalised elderly, in whom malnutrition is common (58 %). In those who cannot be weighed, a higher prevalence of malnutrition and associated poorer clinical outcome supports the importance of routine screening with a tool, like ‘MUST’, that can be used to screen all patients.

Malnutrition: Screening: Elderly: Validity: Outcome assessment

Malnutrition is common, under-recognised and under-treated across specialities, including elderly care (Mowe & Bohmer, 1991; McWhirter & Pennington, 1994; Morley, 1998; Kelly et al., 2000, Waitzberg et al., 2001, Stratton et al., 2003b). Several studies have surprised health workers by revealing that about two-thirds of patients with malnutrition, including elderly patients, were unrecognised (Mowe & Bohmer, 1991; Kelly et al., 2000). To combat this problem many national and international organisations have recommended that nutritional screening should be routinely undertaken in hospitalised patients to identify those likely to benefit from nutritional intervention: British Dietetic Association (1999), Department of Health (2001), Council of Europe (2002), British Association for Parenteral and Enteral Nutrition (Elia, 2000, 2003), ESPEN (Kondrup et al., 2003), ASPEN (1995), Royal College of Physicians (2002) and NHS Quality Improvement Scotland (2003). Screening has become a mandatory standard in some countries (NHS Quality Improvement Scotland, 2003) and so the choice of a screening tool is obviously an important issue. There are many valuable tools that have been developed, validated and are widely used for the detection of malnutrition in clinical practice, including Subjective Global Assessment (Detsky et al., 1987), Mini-Nutritional Assessment (MNA; Guigoz et al., 1996) and its short form (SF-MNA; Murphy et al., 2000), Nutrition Risk Screening (Kondrup et al., 2003) and ‘Malnutrition Universal Screening Tool’ (‘MUST’; Elia, 2003). Amongst the desirable characteristics of screening tools are that they are easy and quick to perform, particularly in busy hospital wards, acceptable to patients and health care workers, and have good reproducibility and validity. An important type of validity is predictive validity or the ability to predict clinical outcome, with its economic implications. Although many studies have linked malnutrition, identified by a variety of screening tools, to poor clinical outcome (for a review, see Elia et al., 2005), the available literature on the predictive validity of nutrition screening tools for elderly hospitalised patients is inadequate for at least two reasons. First, there is a notable lack of information about the value of simple quick screening tools for predicting clinically relevant outcome measures. Although both the full MNA (Guigoz et al., 1996) and the Subjective Global Assessment (Detsky et al., 1987) have been related to outcome, they can be lengthy to undertake and potentially impractical for routine use by a variety of health care workers in busy clinical wards (Stratton et al., 2004), which is partly why a shorter form of the MNA was developed (Murphy et al., 2000). Second, a number of tools (e.g. MNA (Guigoz et al., 1996), SF-MNA (Murphy et al., 2000), Nutrition Risk Screening (Kondrup et al., 2003), Nutrition Risk Score (Reilly et al., 1995)) do not explicitly state how to use the

Abbreviations: MNA, Mini-Nutritional Assessment; ‘MUST’, ‘Malnutrition Universal Screening Tool’; SF-MNA, short form of the Mini-Nutritional Assessment.

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tool in those patients who cannot have measurements of weight and/or height undertaken. Similarly, these tools do not appear to have been validated using any such alternatives (e.g. use of recalled values or subjective criteria). For some hospitalised patients, particularly elderly care patients, it may be difficult or impossible to obtain measurements of weight or height. Studies in acute hospitals have failed to establish malnutrition risk in up to 56% of patients because of difficulties in measuring weight and/or height (particularly in medical patients) (Kelly et al. 2000; Powell-Tuck & Hennessy, 2003). A particularly high figure may be expected in elderly care wards that manage severely frail, disabled individuals who are often bed-bound. Consequently, many studies lack complete information on the prevalence of malnutrition and the associated clinical outcome of this potentially vulnerable patient group. In contrast to many screening tools that require measurement of weight to be undertaken to establish malnutrition risk, ‘MUST’ (Elia, 2003; www.bapen.org.uk) for adults has been developed as a tool that can establish malnutrition risk in all adult patients, even in those in whom weight and/or height cannot be measured. It does this by using recalled or surrogate measurements for weight, height or BMI, and other more subjective criteria when necessary. Previous work has established that correct categorisation of patients whose weight (and/or height) could not be measured could be established with a sensitivity and specificity of ≥ 95% (Elia, 2003). Studies have also indicated the concurrent validity of ‘MUST’ with other screening tools (including MNA, SF-MNA and Subjective Global Assessment) in use in clinical practice (Stratton et al. 2004). This investigation had three aims: (1) to test the hypothesis that ‘MUST’ could be undertaken on all admissions to elderly care wards, enabling malnutrition prevalence to be established for everyone, including those who could not be weighed (and hence screened by other commonly used tools); (2) to assess the predictive validity of ‘MUST’ with regard to clinical outcome in the group as a whole and in the subgroup of patients who could not be weighed; (3) to investigate whether malnutrition and poor clinical outcome were more prevalent in elderly patients in whom weight (measured or recalled) could not be obtained.

Subjects and methods

Local Research Ethics Committee approval was obtained. Patients gave consent before being screened and <2% of patients declined to participate. Included in the study were 150 consecutive emergency admissions (100 female, fifty male) from home and care homes to two elderly care wards (mean age 85 (SD 5·5) years; see Table 1). Reasons for admittance to home and care homes to two elderly care wards (mean age 85 (SD 5·5) years; see Table 1). Reasons for admittance

| Table 1. Patient characteristics according to malnutrition risk |
|---------------------------------|---|---|---|---|
|                                | All | Low | Medium | High |
| n (%)                          | 150 | 63  | 25     | 62   |
| Mean age in years              | 85  | 85  | 86     | 86   |
| Mean age SD                    | 5±5 | 4±5 | 4±5    | 6±6  |
| No. of males                   | 50  | 16  | 10     | 24   |
| No. of females                 | 100 | 47  | 15     | 38   |
| Percentage admitted from nursing/residential care* | 17  | 9±5 | 8      | 29   |

*Three malnutrition categories (low, medium, high), χ² = 0.006; χ² = 10.1.

Height was measured to the nearest 0·1 cm using a portable, free-standing stadiometer (Seca, Leicester, UK), according to standard methodology (Elia, 2003). If height could not be measured accurately (e.g. patient unable to stand), recalled height (if reliable and realistic) (Elia, 2003; Stratton et al. 2003a) or surrogate measures (e.g. knee height) (Elia, 2000, 2003) were used to calculate height. Weight was measured to the nearest 0·01 kg using Seca clinical scales (conforming to EU Directive 90/384/EEC). If weight could not be measured accurately, recalled weight (if reliable and realistic) was used (Elia, 2003; Stratton et al. 2003a). BMI (kg/m²) was calculated and scored accordingly. If neither weight nor height could be obtained, subjective criteria assessing physical appearance (very thin, thin etc.), were used. Percentage unplanned weight loss over 3–6 months was calculated, either from documented weights in patients’ notes or from patients’ reports, and scored accordingly. Subjective criteria could be used if reliable records or reports could not be obtained (Elia, 2003). It was noted if there had been or was likely to be no nutritional intake for >5 d (termed an ‘acute disease effect’ in the tool) and this was scored. For a detailed explanation of the methods and evidence base for ‘MUST’ and interpretation of an ‘acute disease effect’, see Elia (2003), Todorovic et al. (2003) and www.bapen.org.uk.

A record was made of the proportion of patients who could be screened with ‘MUST’ and the prevalence of malnutrition risk (low, medium, high; or combined into two risk categories (low and medium + high risk)). The patients who could not be weighed or have their height measured were identified and their ‘MUST’ malnutrition risk established using recalled/ documented values, surrogate measures and subjective criteria. The time taken to complete screening was recorded and the ease of use on a four-point Likert scale (very easy, easy, difficult, very difficult) assessed. At the time of the study, nutritional screening was not routinely carried out on these wards. The results of screening in the present study were not divulged to the nursing staff so that care continued routinely according to local policy.

Predictive validity

To assess predictive validity, length of hospital stay (days), inhospital mortality, discharge destination (e.g. own home, residential home, nursing home), post-discharge mortality (3- and 6-month) and hospital readmission rates (3 month) were prospectively assessed for each patient and related to ‘MUST’ categorisation.
ANOVA was used to compare mean results or the Kruskal–Wallis one-way ANOVA test was undertaken if data were not normally distributed. Length of hospital stay and readmissions were assessed using Kaplan–Meier Survival Analysis and the log rank test to take into account mortality (similar results (not reported) were obtained by excluding patients who died from analysis using Kruskal–Wallis ANOVA). Differences in proportions were analysed using $\chi^2$ and the influence of other variables (e.g. age) was assessed using binary logistic regression. Data are presented as means and standard deviations or median and range unless otherwise indicated. Analysis was undertaken using SPSS statistical software package version 11.0 (SPSS, Woking, Surrey, UK).

### Results

**Practicality of ‘MUST’ and prevalence of malnutrition risk**

All patients ($n = 150$) were screened using ‘MUST’ enabling malnutrition risk and the prevalence of malnutrition to be calculated for the whole group. Most patients (58%, $n = 87$) were at risk of malnutrition (17% ($n = 25$) medium and 41% ($n = 62$) high risk using ‘MUST’); 28% ($n = 42$) of patients had a BMI $< 20$ kg/m$^2$ (BMI score $\geq 1$); 35% ($n = 52$) had $> 5\%$ unintentional weight loss in 3–6 months (weight loss score $\geq 1$); 25% had an ‘acute disease effect’ (score 2). There were no significant differences between low-, medium- and high-risk patients with regard to age or the proportion of men and women but significantly more patients who were at malnutrition risk (23% of medium + high-risk group v. 9% of low-risk group) were admitted from institutions (nursing and residential homes) than from home (Table 1). During admission, there was little overall change in weight (for patients who could be weighed on both admission and discharge, $+0.41$ (SD 2.84) kg, $n = 79$) and no significant difference between patients who were ($+0.58$ (SD 3.5) kg) or were not ($+0.18$ (SD 3.5) kg) at risk of malnutrition on admission. During screening with ‘MUST’ (within 72 h of admission), weight could be measured in only 56% ($n = 84$) of patients. In a further 21% ($n = 31$) weight was obtained from reliable recall. In these 115 patients, measurement of height could only be undertaken in 16% ($n = 18$) and in most cases was obtained from reliable recall or recent documentation ($n = 58$) and surrogate measures ($n = 39$) (measurements of height not undertaken if data on weight could not be obtained). For thirty-five patients (23% of group; main diagnoses cerebrovascular accident, falls, extreme frailty with severe chest infection), no data on weight could be obtained from measurements or recalled values and so ‘MUST’ subjective criteria were used to categorise malnutrition risk. ‘MUST’ was rated as ‘easy’ to use and took approximately 3–5 min per patient.

**Predictive validity of ‘MUST’**

Mortality and length of stay. In-hospital mortality rose significantly with increasing malnutrition risk category (Fig. 2).

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**Statistical analysis**

ANOVA was used to compare mean results or the Kruskal–Wallis one-way ANOVA test was undertaken if data were not normally distributed. Length of hospital stay and readmissions were assessed using Kaplan–Meier Survival Analysis and the log rank test to take into account mortality (similar results (not reported) were obtained by excluding patients who died from analysis using Kruskal–Wallis ANOVA). Differences in proportions were analysed using $\chi^2$ and the influence of other variables (e.g. age) was assessed using binary logistic regression. Data are presented as means and standard deviations or median and range unless otherwise indicated. Analysis was undertaken using SPSS statistical software package version 11.0 (SPSS, Woking, Surrey, UK).
greater proportion of high-risk patients (51%) did not return weight loss over 3–6 months (weight loss score 1 or more) significantly greater in individuals with the overall ‘MUST’ score (mortality (‘acute disease effect’) had a significant effect on tic regression, each of the individual component scores (BMI, weight loss, ‘acute disease effect’) had a significant in-hospital mortality effect (31% (14 deaths)) and 6 months (21% (25 deaths)) after discharge was also significantly greater for medium- and high-risk patients (5% and 24% at 3 months (P=0.01); 9% and 28% at 6 months (P=0.002), respectively) compared with low-risk patients (5% at 3 months and 13% at 6 months). Length of hospital stay increased progressively with malnutrition risk category (low-risk median 15 d (95% CI 11, 19 d); medium risk 24 d (95% CI 16, 32 d); high risk 28 d (95% CI 21, 35 d); P=0.02, Kaplan–Meier and log rank test) (see Fig. 2). (The length of stay of patients who died did not differ significantly according to ‘MUST’ category; Kruskal–Wallis ANOVA.)

The individual components of ‘MUST’ also predicted clinical outcome (Fig. 3). Individuals with a BMI < 20 kg/m² (BMI score 1 or more) had a significantly greater in-hospital mortality than those with a BMI ≥ 20 kg/m² (BMI score 0) (31% v. 14.3%, P=0.02, χ² 5.40). Similarly, mortality was significantly greater in individuals with >5% unintentional weight loss over 3–6 months (weight loss score 1 or more) than in those with <5% loss (weight loss score 0) (30.8% v. 12.6%, P=0.007, χ² 7.17). Patients with an ‘acute disease effect’ also had significantly greater mortality than those without (36.8% v. 12.8%, P=0.001, χ² 10.52). Using binary logistic regression, each of the individual component scores (BMI, weight loss, ‘acute disease effect’) had a significant effect on mortality (P=0.023, P=0.009, P=0.002 respectively), as did the overall ‘MUST’ score (P=0.009).

Discharge destination and readmissions. Although a greater proportion of high-risk patients (51%) did not return home after hospital discharge (v. 40% of the low-risk group), this was not significant. There was also no difference in the proportion of patients readmitted to hospital (29% v. 23%), the number of readmissions to hospital (median 0 (range 0–2) for all risk categories) or the number of days spent in hospital on readmissions (0 (range 0–48) d v. 0 (range 0–52) d) up to 3 months post-discharge, according to ‘MUST’ category (low v. medium + high).

Malnutrition risk and clinical outcome of patients who could v. could not be weighed

Patients who could not have their weight measured during screening (n 66) had a greater prevalence of malnutrition (70%) than those who could be weighed (49%) (P=0.01, χ² 6.6). Malnutrition prevalence (medium + high risk) was greatest (89%) in the thirty-five patients for whom ‘MUST’ subjective criteria were used to calculate risk (patients who could not be weighed with no recalled weight). These patients were more likely to be malnourished and to have significantly poorer outcome (higher mortality, longer length of stay, greater need for support post-discharge) than those who could be weighed (Table 2).

Predictive validity of ‘MUST’ in patients who could v. could not be weighed

The relationship of ‘MUST’ malnutrition risk (low v. medium + high) to increased mortality was observed both in patients whose weight could and could not be measured during screening (Fig. 4). In patients who could not be weighed and whose malnutrition risk was categorised using recalled weight or subjective criteria (n 66), those at malnutrition risk (medium + high ‘MUST’) had significantly greater mortality compared with those who were at low risk (34.8% v. 5.3%; P=0.014, χ² 6.07; Fig. 3) (for patients screened using only subjective criteria, the mortality in medium + high- v. low-risk patients was 45.2% v. 0%, respectively (n 35; P=0.08, χ² 3.01; data not shown in Fig. 3).

There were no significant differences in mortality between low-risk patients who could and could not be weighed during screening with ‘MUST’ (Fig. 4). However, there was a tendency (not significant) for medium + high-risk patients who could not be weighed to have higher mortality than those who could be weighed (Fig. 4).
Consequently, studies of malnutrition prevalence and its relationship to outcome have often excluded patients who could not be weighed (Kelly et al. 2000; Powell-Tuck & Hennessy, 2003). Crucially, however, in the present study, all consecutive patients could be screened with ‘MUST’ (n=150) and malnutrition risk documented, enabling a more complete picture of the prevalence of malnutrition and its impact on clinical outcome to be assessed for all patients in this group. This was despite there being 44% (n=66) of patients who could not be weighed. These individuals (n=66) could still be screened using ‘MUST’ due to the use of recalled and subjective criteria incorporated within ‘MUST’ (for reliability see Elia, 2003; Stratton et al. 2003a). Measurement of height was also difficult in this group (possible in eighteen of the 150 patients – 12% of the whole group) and so recalled/documented heights and surrogate measures to calculate height enabled BMI to be calculated for those for whom a weight could be obtained (Elia, 2003).

The present study also investigated the predictive validity of ‘MUST’. In this patient group, ‘MUST’ risk predicted some clinical outcomes, namely mortality both in hospital and 3 and 6 months after discharge and length of hospital stay (Fig. 2). Discharge to destinations other than home and readmission rates were not significantly different in those with malnutrition (medium + high risk). However, it is widely acknowledged that admission and discharge to institutions are affected by many factors, often socially determined and which may be independent of nutritional status. Alternatively, in the present study, the sample size may have been inadequate to detect differences. The individual components of ‘MUST’ were significantly related to outcome (Fig. 3). In addition, the relationship between ‘MUST’ risk and outcome (e.g. in-hospital mortality) persisted in those patients for whom only recalled or subjective data were used to categorise ‘MUST’ risk (Fig. 4).

Importantly, the present study also highlighted that patients who could not have their weight measured (nor reliable data on recent weight obtained) were significantly more likely to be at malnutrition risk and to have a poorer outcome (Table 2).

The high prevalence of malnutrition (58%) and the associated poorer clinical outcome of this elderly patient group is concerning. The present findings support the consensus of recommendations made by many national and international bodies that routine screening to identify malnutrition should be carried out so that patients can be treated (Elia et al. 2005). Indeed, systematic reviews and meta-analyses have suggested that the use of oral nutritional support in many patient groups, including the elderly, can significantly improve clinical outcome (mortality, complication rates) and body function in the treatment of malnutrition.
(Potter et al. 1998; Stratton & Elia, 1999; Potter, 2001; Stratton et al. 2003b), despite the problems with anorexia and early satiety in the elderly (Morley, 1996).

Although one of the main aims of the present study was to assess the predictive validity of ‘MUST’, other types of validity for screening tools are also important, as a standard reference method to diagnose malnutrition is lacking. Indeed, in addition to being reliable and reproducible, ‘MUST’ has concurrent validity with other published tools (Elia, 2003; Stratton et al. 2004).

One issue that remains to be fully addressed by well-designed randomised controlled trials is the impact of intervening with a screening programme (that includes screening and treatment), on the care and clinical outcome of patients, including those who are and are not identified as at risk (Elia et al. 2005). Although improvements in outcome have been observed in patients treated for risk of malnutrition (after identification with screening; Johansen et al. 2004), randomised controlled trials that study the effects of screening and associated care plans in all patients (with and without malnutrition) are lacking.

In conclusion, this is the first study to show that ‘MUST’ has predictive validity in the elderly hospitalised population, with regard to mortality, both in hospital and after discharge, and length of hospital stay. In the present study, the individual components of ‘MUST’ related to outcome (mortality), and the relationship between ‘MUST’ and poorer outcome persisted when only recalled or subjective data could be used in ‘MUST’ risk categorisation. ‘MUST’ could be used to screen all of the elderly care inpatients, in whom the prevalence of malnutrition was high (58 %). Those who could only be screened using ‘MUST’ subjective criteria (e.g. no measured or recalled weight) had the highest prevalence of malnutrition (89 %) and the poorest clinical outcome. The present findings highlight the importance of using a method to identify malnutrition that can be used in all patients in routine practice so that a suitable, evidence-based treatment plan can be implemented, with a view to improving clinical outcome.

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References