Policies and Procedures for Remote Work During a Pandemic

Inability to Visit Facilities in Person

Policy:

In the event of a pandemic, in person visits for registered dietitian nutritionists (RDN) and nutrition and dietetics technicians, registered (NDTR) may not be possible due to the government or individual facility mandates, need to self-isolate or self-quarantine, or other reasons. In the case of inability to visit facilities in person, each RDN and/or NDTR will follow the procedure outlined below.

Procedure:

The RDN and/or NDTR will:

1. Contact the facility and obtain information using telephone, secure EHR, email, or fax if consults need immediate attention.
2. Reschedule the visit within a reasonable period of time. If the visit cannot be rescheduled for a week or more and the facility has remote access via electronic health records (EHR):
    a. Complete nutrition documentation remotely.
3. If documentation is not available from remote access using the EHR:
    a. Contact the facility by phone to set up systems for consults and documentation.
    b. Ask the nurse or other appropriate personnel to document nutrition recommendations.
    c. Document the conversation in writing, and place the hard copy in the chart on the next visit, or document it into the EHR system on the next visit.
4. Contact each facility on a regular basis to determine resident/facility needs and provide consultation as needed. Use the referral form checklist to ask about their needs. The checklist should be shared with the facility to save time on the phone call.
5. The following areas may be issues of concern during emergency situations:
    a. Food Service:
        i. Emergency food, water and supplies
        ii. Sanitation and food safety
        iii. Isolation trays and food handling
        iv. Preparation of food when short staffed in the kitchen
        v. Preparation of modified diets

        Note: See Policy & Procedure Manual chapters 1-5 and 12
    b. Clinical:

See the following pages for information on referrals, additional related policies, procedures, and forms.

6. The RDN will complete a written report for the facility including:
    a. A notation that the visit was delayed and/or they worked remotely because of the pandemic. (This documents that the RDN is completing work in a timely manner in case of questions by surveyors in future).
    b. A notation that the RDN will do follow up documentation at the next visit. (Keep a detailed list of which residents/patients need to be followed up with.)
7. Record in the nutrition progress note in the EHR (or handwritten/typed documentation) that documentation was completed remotely, the reason why, and that the RDN will follow up in person at the next routine visit to the facility.
8. For facilities that do not have EHR, the facility must provide specific information as needed for the RDN to document remotely.
9. The RDN and facility will communicate using a secure fax. The facility staff will file the faxed documentation records in the paper medical record.

Policies and Procedures for Remote Work During a Pandemic

Nutrition Screening for Referrals to the Registered Dietitian Nutritionist

Policy:

Facility staff will screen individuals for nutrition risk upon admission, at regular intervals, or whenever a change in condition warrants, using a validated nutrition screening tool and approved process.

Procedure:

1. Staff will use a validated screening tool, such as the Malnutrition Screening Tool (MST), to determine the presence or risk for malnutrition. The screening process may also include additional criteria associated with other nutritional risk(s).
2. The facility will designate responsibility for completing the nutrition screening form. Nursing staff may complete the nutrition screening during initial assessment, or the nutrition support staff may complete it during the initial visit when they obtain food preferences and determine needs and concerns.
3. Facility staff will follow directions to complete the validated screening form upon admission, quarterly, annually, after readmission following a hospital stay, and/or with any significant change in status health.
4. Staff will communicate the results of the nutrition screening process with the registered dietitian nutritionist (RDN) or designee, and provide information for individuals with:
    a. Malnutrition as indicated by the screening tool (MST scores 2 or More are at risk)
    b. And other criteria as determined by a facility's screening tools or protocols (see policy on *Referral to the RDN*).
5. The RDN, nutrition support staff and/or nurse manager will initiate appropriate interventions, as necessary, for the individual patient/resident. The RDN or designee will complete a comprehensive nutrition assessment based on the information available/provided, and determine appropriate nutrition interventions.
6. The facility staff or RDN or designee should notify the physician in writing, when an individual's nutrition screening indicates malnutrition. The physician should review the information during the next scheduled visit.
    a. As an alternate option, the facility may choose to use the MST as an internal document which is reviewed by the RDN during the next scheduled visit. In this case, the RDN will document in the medical record interventions or changes to the care plan as appropriate.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (CDM), director of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.

Policies and Procedures for Remote Work During a Pandemic

Referrals to the Registered Dietitian Nutritionist (RDN)

Policy:

Facility staff will refer high-risk individuals to the RDN for assessment and nutrition intervention as needed.

Procedure:

1. The nutrition support staff, director of nursing, or designee will provide appropriate referrals to the RDN or designee including but not limited to:
   a. New or re-admissions to the facility
   b. Physician-ordered nutrition consults
   c. Malnutrition risk score on MST of 2 or more, or as determined by the specific nutrition screening tool.
   d. Others as determined by the facility may include but are not limited to:
      - Enteral/parenteral feedings
      - Significant weight changes (loss or gain)
      - Unplanned gradual weight loss
      - Pressure injuries and other wounds
      - Dehydration risk
      - Dialysis or renal diets
      - Fluid restriction
      - Terminal condition
      - Need for nutrition education
      - Poor food/fluid intake
      - Poorly controlled diabetes
      - Chewing, swallowing or gastrointestinal problems
      - Diet orders not available on the menu
      - Desire to refuse diet as ordered
2. Facility staff will use the referral form provided to notify the RDN or designee of any problems as they arise. If the problem is urgent, facility staff will notify the RDN or designee of the problem by phone or secure email or fax and provide supporting information as requested by the RDN. (See *Sample Referrals for Registered Dietitian Nutritionist Forms* on the following pages.)
3. Facility staff will leave the referral form at a pre-agreed upon location in the facility, or communicate this information using a secure means. Facility staff should complete the referral form weekly or more often if needed, and provide it to the RDN or designee.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (CDM), director of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.

Sample Referrals for Registered Dietitian Nutritionist Form (1)

Facility Name:_____ **Date:**_____

Referral Date	Completed	Room Number	Name	New/ Re-admit/ Annual/ Quarterly Assessment	Screened for Referral (MST Score of 2 or more)	Physician Ordered Consult	Enteral / Parenteral Feeding	Significant Weight Loss or Gain (or insidious loss)	Pressure Injury or Wound	Dehydration risk	Dialysis, Renal Diet or Fluid Restriction	Terminal Condition	Annual Assessments	Needs Nutrition Education	Desire to Refuse Physician-Ordered Diet	Other	Comments

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Policies and Procedures for Remote Work During a Pandemic

Sample Referrals for Registered Dietitian Nutritionist Form (2)

Facility: Name_____ **Date:**_____

Room Name	New/Re-admit/ Annual/Quarterly	MD Consult Order	Mal-nutrition	Significant Weight Loss/Gain	Pressure Injury or Wound	Risk of or Resolving Dehydration	Terminal Condition	Enteral/ Parenteral Feeding	Needs Nutrition Education	Fluid Restriction	Refuses Diet	Other/Comments

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Policies and Procedures for Remote Work During a Pandemic

Remote Documentation When Electronic Health Records are Not Available

Policy:

When the facility does not have electronic health records (EHR) and information needs to be gathered to complete an assessment, re-assessment and/or care plan, this checklist is used as a reminder of information needed to assure that all information is gathered. The checklist may be used during a phone call with facility staff.

Procedure:

1. When the registered dietitian nutritionist (RDN)/nutrition and dietetics technician, registered (NDTR) receives a referral from a facility that does not have remote access and/or EHR, she/he calls the facility to gather information obtained from designated facility staff, using either a nutrition assessment or re-assessment form or care plan form, or checklist as appropriate to assure all information is available for the comprehensive nutrition assessment, re-assessment and/or care plan.
2. The RDN/NDTR will ask pertinent questions under each category to gather as much information as possible for each referral.
3. The RDN/NDTR will keep a copy of the information gathered, complete the documentation using the appropriate form, and fax the documentation to the facility.
4. Facility staff will place the documentation in the hard copy chart in the appropriate location.
5. The RDN/NDTR will follow up on the individual as needed via conference call if still not able to visit the facility in person.
6. The RDN/NDTR will follow up in person at the next available time when allowed to return to the facility.

Policies and Procedures for Remote Work During a Pandemic

EMR Documentation Guidelines

Often in EMRs (Electronic Medical Records), formal nutrition assessment forms are not available or may not be in an efficient format. In order for an assessment in a progress note format to be thorough and complete, guidelines and suggestions for specified types of assessments are provided.

EMR Documentation Guidelines	
New Admission **Readmission** **Significant Change** **Annual**	Ht/CBW/BMI, WNL or not, UBW (Usual body weight) Weight hx/change Diet and supporting dx (include any adaptive equipment/feeding issues, allergies, etc.) Pertinent labs/meds Therapy issues Skin status Presence of edema per nursing assessment or observation Client/visitor/staff interview data Estimated needs calculations Intake assessment PES statement Interventions if needed Goals and Follow up plan *Keep in mind "physical focused assessment": muscle wasting, skin turgor, edema, sunken eyes, appearance of weight gain or loss.
Quarterly ** This template can be used for 14/30/60 day PPS*	CBW/BMI, WNL or not Weight change if any Current diet and supporting dx (Quarterly) Pertinent labs Med changes if any Skin changes Intake assessment Intervention/Follow up plan if needed
SWL/SWG Assessment	CBW and the loss/gain % BMI, WNL or not Current diet/MNT Current meds Pertinent dx Client/visitor/staff interview data Estimated needs calculations Intake assessment PES statement Intervention change with rationale Follow up plan Additional suggestions for assessing sig weight changes: check BM status, constipation, diarrhea; edema/CHF/SOB; recent IV fluids or TF changes; error in obtaining weight; attachments to w/c, cast or equipment changes; changes in activity level; diuretic changes; s/s dehydration, medication side-effects

Policies and Procedures for Remote Work During a Pandemic

Weekly weight update	CBW Stable/change acceptable or not Intake assessment Nutrition supplements/fortified foods Team meeting information if any
	Intervention change with rationale Follow up plan
Wound Assessment	Wound status As referred by staff or per wound report. Avoid "in house acquired". Status of wound if F/U note (improved, healing, deteriorated). May indicate if there has been a treatment change or if wound clinic or if wound MD/CNP follows. CBW, gain/loss, BMI Nutrition supplements/fortified foods Estimated needs assessment Pertinent labs Intake assessment Intervention /changes if needed Follow up plan
Monthly Enteral/Parenteral Assessment	CBW/ BMI, WNL or not Weight change if any Supporting dx for TF/TPN Tolerance issues Pertinent labs Estimated needs vs provided kcal/pro/fluids Intervention if needed Follow up plan
Suggestions for Weight & Wound Team Meetings	Delegated dependent upon assigned responsibilities, contract hours, skill level of needs: Prepare list of weights needed for next week and give to responsible person. Add any new or readmits, new additions or removal of weekly weights. As time permits prior to meeting, investigate any 3% or more changes in a weekly weight: med changes, labs, edema, intakes, etc. Meeting tips: be confident! You are the leader! Stay on task during the meeting. Record pertinent IDT feedback that can be used for your documentation later, including SLP data for MDS triggers. Determine by policy/need if weekly weights should continue.

Checklist for Nutrition Consult via Telephone or other Form of Communication

This form can be used as a guideline for phone conversations with staff at facilities that do not have electronic health records (when paper charting must be done remotely).

For Individual Nutrition Consults:

- ☐ Diagnosis
- ☐ Diet order
- ☐ Food allergies/intolerances
- ☐ Height/current weight/date
- ☐ Recent weight changes including dates (30/90/180 days)
- ☐ Presence of wounds, UTIs etc.
- ☐ P.O. intake/appetite
- ☐ Medications (insulin, Metformin, Lasix, etc.).
- ☐ Pertinent lab values
- ☐ TF/TPN/IV fluids
- ☐ Follow up on this individual by phone or at next in-person visit. Notes:
- ☐ Date completed:

Policies and Procedures for Remote Work During a Pandemic

For Food and Nutrition Services Consults:

- Emergency food, water and supplies
- Sanitation
- Food safety
- Isolation trays and food handling
- Preparation of food when short staffed in the kitchen
- Meal service
- Preparation of modified diets
- Other

Medical Nutrition Therapy Assessment

Name **Room/ID No.** **Physician** **Gender** M / F **DOB** **Age**

Assessment Type: Initial / Quarterly / Yearly / Significant change

NUTRITION ASSESSMENT (Problems/Etiology/Signs & Symptoms)

Ht (inches)
□ Actual
□ Estimated
Wt (#) (Date)
UBW (#)
Adj. BW (#)(Amputation)

BMI _____
□ **<18.5** **Underweight**
□ 18.5-24.9 Normal Weight
□ 25-29.9 Overweight
□ ≥30 Obese
□ ≥40 Extremely Obese

Weight Changes
Wt (#)/(Date) _____ ( ) ↑ ↓ 5% in 1 mo
Wt (#)/(Date) _____ ( ) ↑ ↓ 10% in 6 mo
Planned Weight Change? Y / N **Comments:**

Diet Order Reg / NAS / Mech Soft / Puree / Other:_____
Food allergies / Intolerances
Location of Meals Rm / DR **Restorative Dining** Y / N
Adaptive Eating Device

Oral Nutrition Supplement / Snacks
Fluid Restriction Y / N _____ mL/day
Food/fluid intake adequate to meet estimated needs? Y/N

Alternate Feeding Orders PPN/ TPN/ IV / Tube feeding (including flush orders):
_____mL Formula = _____ Kcals ____ g protein ____% RDI (_____mL FF + _____ mL flush) = _____ Total mL Fluids
Appropriate Y / N **Tolerated** Y / N **Changes Needed** Y / N **Comments:**

Medication Interactions (Circle all that apply)
Antibiotics Cardiac Meds Diuretics Laxatives Psychotropics New Meds / Other:

Labs (Date _____)
H/H _____ HgbA1c _____ Glu _____ Na _____ K+ _____
Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr _____

Other Pertinent Data (Date_____)

Alteration in Nutrition and/or Hydration Status as Evidenced by (Check/Circle all that apply)

□ Abnormal Labs (Refer to data above)
□ Altered Taste
□ Alternate Feeding: TF / IV / TPN
□ Altered Hydration: Dehydration / Edema / Overhydration / Fluid restriction
□ Anemia
□ Cancer / Chemo / Radiation
□ Cardiovascular: CVD / CVA / TIA / CHF / HTN / PVD
□ Dysphagia/ Chewing/Swallowing Problem
□ Communication Difficulty:
□ Cultural/Religious Food Issues
□ Dementia/Cognitive Decline /Depression
□ Diabetes
□ Failure to Thrive
□ ↑ ↓ Food / Fluid Intake
□ Fracture:
□ GI Issues:
□ Hepatic (Liver) Disease
□ Hunger (Complains of)
□ Infection / Fever / Sepsis /URI/ UTI
□ Kidney Disease / Dialysis
□ Malnutrition / Undernutrition
□ Mobility Issues:
□ Neurological / Muscular Disease:
□ Obesity
□ Pain Affecting Eating
□ Pressure Ulcer Risk Score_____
□ Pressure Ulcers/Wounds / Wound VAC:
□ Pulmonary Condition / COPD
□ Self Feeding Difficulty
□ Significant Weight Change: Loss / Gain
□ Surgery (Recent):
□ Terminal Status
□ **Other:**

Data Gathered by: **Date:**

Nutritional Needs Estimation (Based on CBW)

Total Kcal Needs:
Kg Wt X 25 / 30 / 35 +500 cal to gain/ -500 cal to lose

Protein Needs (g)**:**
Kg Wt X 0.8 / 1.0 / 1.25 /1.5

Fluid Needs (mL)**:**
Kg Wt X 25mL/ 30mL/ 35 mL / 1 mL/kcal

PES STATEMENT Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention. See Nutrition Diagnosis, Prescription & Intervention

Education Needs

NUTRITION DIAGNOSIS

NUTRITION PRESCRIPTION & INTERVENTION

NUTRITION MONITORING
Weight / Labs / Skin / Diet / TF Tolerance

Proceed to Care Plan Y / N **Proceed to Care Area Assessment** (CAA) Y / N **Comments**

Signature: **Date:**

Medical Nutrition Therapy Notes

Name _____ **Room** _____

See Plan of Care for Problems, Goals and Interventions

Medical Nutrition Therapy Re-Assessment

Name: _____ Physician: _____ Room: _____

Ht	UBW	BMI	DOB	Age	M / F
		□ <18.5 Underweight □ 18.5-24.9 Normal Weight □ 25-29.9 Overweight □ ≥30 Obese □ ≥40 Extremely Obese			

Estimated Nutritional Needs (Based on CBW)

Total Kcal Needs	Protein Needs (gms)	Fluid Needs (mL)	Dining Needs
Kg Wt X 25 / 30 / 35 + 500 kcal to gain / - 500 kcal to lose	1.0 / 1.25 / 1.5	25 / 30 / 35 / 1 mL/kcal consumed	Location changes: Rehab dining: Y / N Adaptive equipment: Independent / Tray set up / Supervision / Limited Assist/ Total Dependence /Adaptive Equipment:

Date _____ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*	**Date** _____ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*	**Date** _____ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*
New Medical Diagnosis	**New Medical Diagnosis**	**New Medical Diagnosis**
Diet Prescription Reg / Mech Soft / Pureed Other:	**Diet Prescription** Reg / Mech Soft / Pureed Other:	**Diet Prescription** Reg / Mech Soft / Pureed Other:
Oral Nutrition Supplements Calories Protein (gms)	**Oral Nutrition Supplements** Calories Protein (gms)	**Oral Nutrition Supplements** Calories: Protein (gms):
TF / TPN / IV Changes	**TF / TPN / IV Changes**	**TF / TPN / IV Changes**
Food/Fluid Intake Adequate to Meet Needs Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N
Weights: CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **10% past 6 Mo**
Lab Changes Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr
Changes in Care / Condition (Meds, ADLs, physical, diagnosis, etc)	**Changes in Care / Condition** (Meds, ADLs, physical, diagnosis, etc)	**Changes in Care / Condition** (Meds, ADLs, physical, diagnosis, etc)
Signature/Date	Signature/Date	Signature/Date
PES STATEMENT Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES STATEMENT** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES STATEMENT** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)
NUTRITION DIAGNOSIS □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:
NUTRITION PRESCRIPTION & INTERVENTION □Continue previous □Change to:	**NUTRITION PRESCRIPTION & INTERVENTION** □Continue previous □Change to:	**NUTRITION PRESCRIPTION & INTERVENTION** □Continue previous □Change to:
Care Plan □Continue previous □Update	**Care Plan** □Continue previous □Update	**Care Plan** □Continue previous □Update
NUTRITION MONITORING Weight / Labs / Skin / Diet / TF Tolerance	**NUTRITION MONITORING** Weight / Labs / Skin / Diet / TF Tolerance	**NUTRITION MONITORING** Weight / Labs / Skin / Diet / TF Tolerance
Signature	Signature	Signature

Medical Nutrition Therapy Care Plan

Name_____Room/ID#_____

Date	Problems/Etiology/Signs/ Symptoms	**Goals** (and Dates)	Nutrition Interventions
	□ Unable to meet nutritional needs □ Under-nutrition related □ terminal diagnosis □ failure to thrive □ no further interventions desired □ end of life wishes and desires	□ Maintain comfort and pleasure and honor wishes □ Safely maintain oral intake for pleasure for as long as possible	□ Provide diet and fluids per physician order □ Provide oral nutrition supplements per physician order □ Provide TF and Flush per order □ Honor all reasonable food desires and preferences □
	Nutriton Quality of Life □ **Decreased related to diagnosis**		□ Adjust diet according to tolerance and desires □ Monitor food/fluid intake □ Encourage PO intake □ Oral nutrition supplement as ordered □ Assist at meals as needed □ Educate as needed □ Medications as ordered □ Monitor diet tolerance □ Monitor TF tolerance □ Follow comfort protocols □ Follow palliative protocols □ Follow hospice protocols
	Nutrition Diagnosis (NI/NB/NC)		**Nutrition Prescription (ND/E/C/RC)**
			Food/Nutrient Delivery (ND)
Intake (NI)	**Inadequate fluid intake**		
			Education
NI	**Malnutrition**		**Counseling**
NI	**Inadequate protein/energy intake**		**Coordination of Care**
Behavior/ Environ-mental NB)			
Function-al (NC)	**Underweight** **Unintended Weight Loss**		

Signature_____ Date_____

Medical Nutrition Therapy Assessment—Assisted Living

Name **Residence** **Physician** **Gender** M / F **DOB** **Age**

Assessment Type: Initial / Readmission / Yearly

NUTRITION ASSESSMENT (Problems/Etiology/Signs & Symptoms)

Ht (inches)
Wt (#)/(Date)
UBW (#)
DBW (#)
Adj. BW (#)(Amputation)

BMI _____
- □ <18.5 Underweight
- □ 19-24.9 Normal Weight
- □ 25-29.9 Overweight
- □ ≥30 Obese
- □ ≥40 Extremely Obese

Weight Changes
Wt (#)/(Date) _____ ( ) ↑↓ 5% in 1 mo
Wt (#)/(Date) _____ ( ) ↑ ↓ 7.5% in 3 mo
Wt (#)/(Date) _____ ( ) ↑ ↓ 10% in 6 mo
Wt (#)/(Date) _____ ( ) ↑ ↓ 1-2% in 7 days
Planned Weight Change? Y / N **Comments:**

Diet Order Reg / Mech Soft / Puree / Other
Food allergies / Intolerances
Location of Meals Rm / DR **Restorative Dining** Y / N
Adaptive Eating Device

Oral Nutrition Supplement / Snacks
Fluid Restriction
Intake of Food/Fluid Adequate to meet estimated needs? Y / N

Alternate Feeding Orders PPN/ TPN/ IV / Tube feeding (including flush orders)
_____mL Formula = _____ Kcals ____ g protein, ____% RDI (_____mL FF + _____ mL flush) = _____ Total mL Fluids
Appropriate Y / N **Tolerated** Y / N **Changes Needed** Y / N **Comments**

Communication Alert / Confused / Unable to communicate

Medication Interactions
Antibiotics Cardiac Meds Diuretics Laxatives Psychotropics New Meds / Other:

Treatments
Chemo / Radiation / Wound VAC / Other:

Labs (Date _____)
H/H _____ HbA1c _____ BS _____ Na _____ K+ _____
Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr _____

Other Pertinent Data (Date_____)

Alteration in Nutrition and/or Hydration Status as Evidenced by (Check/Circle all that apply)

- □ Abnormal Labs (Refer to data above)
- □ Altered Taste
- □ Alternate Feeding: TF / IV / TPN
- □ Anemia
- □ Cancer
- □ CVD / CVA / TIA / CHF / HTN
- □ Chewing / Swallowing Problem
- □ Communication Difficulty:
- □ Cultural Food Issues
- □ Dehydration / Risk
- □ Dementia/Cognitive Decline /Depression
- □ Diabetes
- □ Edema
- □ Failure to Thrive
- □ ↑↓ Food / Fluid Intake
- □ Fracture:
- □ GI Disorder/Issues:
- □ Hepatic (Liver) Disease
- □ Hunger (Complains of)
- □ Infection / Fever / Sepsis /URI/ UTI
- □ Kidney Disease
- □ Malnutrition / Undernutrition
- □ Mobility Issues:
- □ Neurological / Muscular Disease
- □ Obesity
- □ Pain Affecting Eating
- □ PU Risk Score___
- □ Pressure Injuries/Ulcers / Wounds:
- □ Pulmonary Disease
- □ Self Feeding Difficulty
- □ Surgery (Recent):
- □ Terminal Status
- □ Unintended Weight Loss (Significant)
- □ **Other:**

Nutritional Needs Estimation (Based on CBW)

Total Kcal Needs:	**Protein Needs (g):**	**Fluid Needs (mL):**
Kg Wt X 25 / 30 / 35 +500 cal to gain/ -500 cal to lose	Kg Wt X 0.8 / 1.0 / 1.25 /1.5	Kg Wt X 25mL/ 30mL/ 35 mL / 1 mL/kcal

SUMMARY

PES STATEMENT Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention. See Nutrition Diagnosis, Prescription & Intervention

Education Needs:

NUTRITION DIAGNOSIS	**NUTRITION PRESCRIPTION & INTERVENTION**	**NUTRITION MONITORING** Weight / Labs / Skin / Diet / TF Tolerance

Signature: **Date:**

Medical Nutrition Therapy Re-Assessment Updates—Assisted Living

Name: _____ Physician: _____ Room: _____

Ht	UBW	BMI □<18.5 Underweight □19-24.9 Normal Weight □ 25-29.9 Overweight □ ≥30 Obese □≥40 Extremely Obese	DOB	Age	M / F

Estimated Nutritional Needs (Based on CBW)

Total Kcalorie Needs	Protein Needs (gms)	Fluid Needs (mL)	Dining Needs
Kg Wt X 25 / 30 / 35 + 500 kcal to gain / - 500 kcal to lose	Kg Wt X 1.0 / 1.25 / 1.5	Kg Wt X 25 / 30 / 35 / 1 mL/cal consumed	Location changes: Rehab dining: Y / N Adaptive equipment: Independent / Tray set up / Supervise / Cue / Assist / Totally Dependent for Eating:

Date _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*
New Medical Diagnosis	**New Medical Diagnosis**	**New Medical Diagnosis**
Diet Prescription: Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:
Oral Nutrition Supplements Calories : Protein (gms) :	**Oral Nutrition Supplements** Calories : Protein (gms) :	**Oral Nutrition Supplements** Calories : Protein (gms) :
Food/Fluid Intake Adequate to Meet Needs Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N
Weights: CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**
Lab Changes Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr
Changes in Care / Condition (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):
PES Statement: Compromised nutrition and/or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES Statement:** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES Statement:** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)
NUTRITION DIAGNOSIS □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:
NUTRITION PRESCRIPTION/ INTERVENTION □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:
Diet Instruction Provided **Compliance Expected?** Y / N	**Diet Instruction Provided** **Compliance Expected?** Y / N	**Diet Instruction Provided** **Compliance Expected?** Y / N
NUTRITION MONITORING Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet
Signature:	Signature:	Signature:
Signature:	Signature:	Signature:

Medical Nutrition Therapy Notes

Medical Nutrition Therapy Assessment ICF-ID

Name **Residence** **Physician** **Gender** M / F **DOB** **Age**

Assessment Type: Initial / Readmission / Yearly

NUTRITION ASSESSMENT (Problems/Etiology/Signs & Symptoms) **Attends workshop: Yes No**

Ht (inches)

Wt (#)/(Date)

UBW (#)

DBW (#)

Adj. BW (#)(Amputation)

BMI _____

- □ <18.5 Underweight
- □ 19-24.9 Normal Weight
- □ 25-29.9 Overweight
- □ ≥30 Obesity I
- □ 35-39.9 Obesity II
- □ ≥40 Extreme Obesity III

Weight Changes

Wt (#)/(Date) _____ ( ) ↑ ↓ 5% in 1 mo

Wt (#)/(Date) _____ ( ) ↑ ↓ 7.5% in 3 mo

Wt (#)/(Date) _____ ( ) ↑ ↓ 10% in 6 mo

Planned Weight Change? Y / N **Comments:**

Diet Order Reg / Mech Soft / Puree / Other

Food allergies / Intolerances

Adaptive Eating Device

Oral Nutrition Supplement / Snacks

Fluid Restriction

Intake of Food/Fluid Adequate to meet estimated needs? Y / N

Alternate Feeding Orders PPN/ TPN/ IV / Tube feeding (including flush orders)

_____mL Formula = _____ Kcals ____ g protein, ____% RDI (_____mL FF + _____ mL flush) = _____ Total mL Fluids

Appropriate Y / N **Tolerated** Y / N **Changes Needed** Y / N **Comments**

Communication Alert / Confused / Unable to communicate

Medication Interactions

Antibiotics Cardiac Meds Diuretics Laxatives Psychotropics New Meds / Other:

Treatments

Chemo / Radiation / Wound VAC / Other:

Labs (Date _____)

H/H _____ HbA1c _____ BS _____ Na _____ K+ _____

Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr _____

Supplementation by:

Alteration in Nutrition and/or Hydration Status as Evidenced by (Check/Circle all that apply)

- □ Abnormal Labs (Refer to data above)
- □ Altered Taste
- □ Alternate Feeding: TF / IV / TPN
- □ Anemia
- □ Cancer
- □ CVD / CVA / TIA / CHF / HTN
- □ Chewing / Swallowing Problem
- □ Communication Difficulty:
- □ Cultural Food Issues
- □ Dehydration / Risk
- □ Dementia/Cognitive Decline /Depression
- □ Diabetes
- □ Edema
- □ Failure to Thrive
- □ ↑ ↓ Food / Fluid Intake
- □ Fracture:
- □ GI Disorder/Issues:
- □ Hepatic (Liver) Disease
- □ Hunger (Complains of)
- □ Infection / Fever / Sepsis /URI/ UTI
- □ Kidney Disease
- □ Malnutrition / Undernutrition
- □ Mobility Issues:
- □ Neurological / Muscular Disease
- □ Obesity
- □ Pain Affecting Eating___
- □ Pressure Ulcers / Wounds:
- □ Pulmonary Disease
- □ Self Feeding Difficulty
- □ Surgery (Recent):
- □ Terminal Status
- □ Unintended Weight Loss (Significant)
- □ **Other:**

Nutritional Needs Estimation (Based on CBW)

Total Kcal Needs:
Kg Wt X 25 / 30 / 35 +500 cal to gain/ -500 cal to lose

Protein Needs (g):
Kg Wt X 0.8 / 1.0 / 1.25 /1.5

Fluid Needs (mL):
Kg Wt X 25mL/ 30mL/ 35 mL / 1 mL/kcal

Summary

Education Needs:

Nutrition Diagnosis Statement (PES)

Nutrition Prescription Or Intervention

Signature: **Date:**

Medical Nutrition Therapy Re-Assessment/Updates ICF-ID

Name: _____ Physician: _____ Room: _____

Ht	UBW	BMI □<18.5 Underweight □19-24.9 Normal Weight □ 25-29.9 Overweight □ ≥30 Obesity I □35-39.9 Obesity II □≥40 Extreme Obesity III	DOB	Age	M / F

Estimated Nutritional Needs (Based on CBW)

Total Kcalorie Needs	Protein Needs (gms)	Fluid Needs (mL)	Dining Needs Location changes:
Kg Wt X 25 / 30 / 35 + 500 kcal to gain / - 500 kcal to lose	Kg Wt X 1.0 / 1.25 / 1.5	Kg Wt X 25 / 30 / 35 / 1 mL/cal consumed	Rehab dining: Y / N Adaptive equipment: Independent / Tray set up / Supervise / Cue / Assist / Totally Dependent for Eating:

Date _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*
New Medical Diagnosis	**New Medical Diagnosis**	**New Medical Diagnosis**
Diet Prescription: Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:
Supplements	**Supplements**	**Supplements**
Food/Fluid Intake Adequate to Meet Needs Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N
Weights: CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**
Lab Changes Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr
Changes in Care / Condition (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):
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NUTRITION PRESCRIPTION/ INTERVENTION □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:
NUTRITION MONITORING Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet
Comments	**Comments**	**Comments**
Signature:	Signature:	Signature:
Signature:	Signature:	Signature:

Malnutrition Screening Tool (MST)

STEP 1: Screen with the MST

1 Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2

Weight loss score: _____

2 Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score: _____

Add weight loss and appetite scores

MST SCORE: _____

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK

Eating well with little or no weight loss

If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.

MST = 2 OR MORE
AT RISK

Eating poorly and/or recent weight loss

Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutritional support for your patients at risk of malnutrition.

Notes: _____

Ferguson, M et al. *Nutrition* 1999 15:458-464

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