**Policy:**

It is the policy of the Nutrition Services department to provide nutrition care for patients identified at nutrition risk.

**Purpose:**

To assess nutritional needs, develop and implement a nutrition care plan with specified nutritional goals, communicate findings to the health care team, and provide follow-up as appropriate.

**Procedure:**

1. Registered Dietitians (RDs) will complete a nutritional assessment for all patients identified at nutrition risk.
   
   a. Patients are assessed within 48 hours of notification when:
      
      - RN to RD consult (patients found to be at risk upon admission via RN nutrition screening) (Attachment A)
      - Physician ordered consults
      - Patients with Enteral or Parenteral Nutrition Orders
      - Patients are identified at risk through communication with other health care professionals
   
   b. Patients are assessed within 48 - 72 hours of notification when:
      
      - Patients are admitted to the rehabilitation unit or bone marrow transplant service
      - Adults and children > 5 years of age are NPO and/or on clear liquids > 5 days and children < 6 years of age are NPO and/or on clear liquids > 3 days
      - Patients who are NPO and intubated in the ICU
      - Patients are identified to have a high risk admitting diagnosis:
c. All patients screened at low risk upon admission will be re-screened in 7 days.

d. Full nutrition assessments will not be completed on hospice patients or patients who are to be discharged within 24 hours.

e. Neonatal intensive care unit patients will be seen within 72 hours of admission if they are identified at nutrition risk upon nutrition admission screening.

2. Nutrition Care Process

a. Nutrition Assessment

i. Scope of Assessment: The RD, within their scope of practice, collects and analyzes data to assess the patient’s nutrition needs. The RD may attend interdisciplinary patient care rounds in order to gain additional patient information that can be incorporated into the nutrition assessment. Data assessed may include:

- Adequacy of nutrient intake: current, previous and required
- Anthropometric measurements and physical examination
- Pertinent laboratory data and medications
- Food intolerances and allergies
- Religious, cultural, ethnic and personal food preferences
- Diet prescription or number of days NPO (nothing by mouth)
- Lack of economic resources available to comply with the prescribed dietary regimen.
- Calculation of nutrient needs for kilocalories, protein and fluid using information from Manual of Clinical Dietetics (AND) and Patient
Care Guidelines. Other nutrients may also be calculated as warranted by the patient’s medical condition.

- Any additional clinical pertinent information.

b. Nutrition Intervention: Nutrition interventions are planned actions and recommendations designed to improve the nutritional status of the patient and/or change a nutrition related behavior, risk factor, environmental condition or aspect of health status for an individual or group. Dietetics professionals work collaboratively with the patient, family, caregivers and members of the health care team to formulate a plan.

c. Nutrition Monitoring and Evaluation
   i. Monitoring and Evaluation refers to the review and measurement of a patient’s status. A level of care will be assigned (Attachment B) to each patient. Quantifiable nutrition goals will be set that are relevant to the patient’s defined needs and disease state to allow for specific monitoring and evaluation of progress.

3. Communication of the Assessment: The initial nutritional assessment and subsequent care plan are documented in the medical record. RD’s further address the medical nutrition therapy continuum of care through one-on-one dialogue with healthcare staff and at interdisciplinary rounds.

4. Follow-up Care: Patients are assigned a level of risk based on the Level of Care Document (attachment B) during the initial nutrition assessment. Time-lines for follow-ups are determined by this level of care. A patient’s nutrition risk is reassessed on a continuous basis as their condition changes and may be adjusted by the RD at any point when it has been determined the patient condition has changed.

5. Communication between dietitians
   a. Dietitians complete an RD Risk Addendum within the EPIC medical record system as internal communication tool. Date of the consult/follow-up is recorded as well as any other pertinent data. Dietitians view RD Risk Addendum’s daily to prioritize their workload.

   b. When a consult is received for parenteral nutrition the RD will communicate with the designated pharmacist and complete a consult addressing the nutritional requirements of the patient.

   c. The I-S-B-A-R process is used when hand-offs of patients occur:
      I = clearly identify yourself and the name of the patient
      S = what is the situation you are describing related to this patient
      B = what is the background information related to this patient’s situation
      A = what is your assessment of the situation
      R = what is your recommendation or what do you warrant