ADIME 1

Pt screened as malnourished due to decreased mobility/po intake, recent wt loss, psychological stress r/t surgery, and mild dementia: MNA [3].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0. ALLERGIES/INTOLERANCES: bell peppers APPETITE/PO INTAKE: no appetite r/t stress/nausea/vomiting, avg po </= 50% of EER [pt reported, may not be accurate]. CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt does not eat snacks, prefers eating small breakfast/lunch/dinner if there is an appetite, pt reliant upon fluids/drinks SUPPLEMENTS: hosp: none RESIDENT EATS: Independent ADAPTIVE EATING DEVICES: none MEDICATION: VITAMIN D3 1000 IU, VITAMIN B12 1000 MEDICATION WARNINGS r/t psychotropic [ ] : [NO] N/A NUTRIENT TOXICITY r/t psychotropic [ ]: [NO] N/A

ANTHROPOMETRICS - Ht/Wt: 59" / 150.4lbs [68kg], hosp. Wt: 141lbs, Hamwi IBW small frame: 85.5 lbs 175% IBW [AdjBW applicable; AdjBW 46kg] BMI: 26..3 overweight; UBW: 139lbs

WEIGHT CHANGE: + 4% in 1 ½ wks [6lbs] since 1/03/24 hosp; + 7% in 1wk [10lbs] since admit

PLANNED Wt CHANGE PROGRAM: [NO]; wt fluctuation expected r/t cirrhosis

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: hosp :

WBC [H], RDW [H], Platelet [L], absolute Neutrophils [H], absolute Lymphocytes [L], Alb [L], AST [H],

Alkaline Phosphatase [H], Na [L], BUN [L], Cre. [L], GLU mg/dL [H], Ca [L], mg/dL [H]

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [High] w/bruising (Comp skin UDA), very pale color, no

edema noted; ORAL: no chewing difficulties; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily

habit: gets out of bed to use the restroom OVERALL APPEARANCE: anxious/complacent-of-SNF-change/wasted; MUSCLE/FAT

WASTING: severe in temples/buccal-fat-pads/orbital-fat pads/clavicles.

CLIENT HISTORY -

AGE: yrs female /at birth hosp admit: length of stay: +1Wk

hosp Dx: sepsis and cirrhosis

PMH: hepatic failure, cirrhosis, idiopathic acute pancreatitis, esophageal varices, abdominal pain, atrophy of thyroid, Altheimer's disease, dementia, acidosis, DM, hypertension, hyperlipidemia, B deficiency, diverticulosis, vit D deficiency, and MDD

Sx: abdominal pain and nausea/vomiting [pt reports]

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of ; calculated using [AdjBW 46kg]; addressed septic recovery/age/cirrhosis/

Est. Kcal Needs: [30 – 35 kcal/kg AdjBW] = 1,380 – 1,610 kcals

Est. Protein Needs: [1.2 - 1.5 g/kg AdjBW] = 55 g/d – 69 g/d

Est. Fluid Needs: [kcal/mL AdjBW] = 1,380 – 1,610 mL/d

COMMENTS: interview: pt not receptive to receiving menu or documenting like/dislikes, pt declined intervention, pt was not

nervous. f/u to see if pt is developing an appetite, is wt stable, and is satisfied w/food.

NUTRITION DIAGNOSIS

1. SEVERE MALNUTRITION of [CHRONIC DISEASE] r/t increased nutrient needs of kcals, inadequate oral intake, and altered nutrition related labs AEB hosp Dx: sepsis/cirrhosis, abdominal pain, severe muscle/fat wasting of temples/buccal-fat-pads/orbital-fat pads/clavicles, Alb 3.7 [L], and self-reported < 50% EER >1mo

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommended 8oz boost plus DAILY w/breakfast [no preference: provides 360kcals, 14g protein, 14g fat]; pt declined recommended intervention

INTERVENTION(s)

1. patient education

NUTRITION EDUCATION [DI consultation JAN 2024]: Educated pt on the importance of their intake of vit/min and food to recover from sepsis and postpone worsening malnutrition.

COORDINATION OF NUTRITION CARE: See care plan / diet card.

GOAL(s):

1: developing an appetite

2: postpone worsening malnutrition r/t chronic disease

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of meals / [progress notes / intake reports]

2. wt, facial/clavicle muscles/fat-pads, and po intake / [wt reports, NFPE, and intake reports]

Contact RDN or DI if any significant changes in wt or po intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 2

Pt screened as at risk for malnutrition due to decreased mobility, increased psychological stress r/t acute injury; MNA [11].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0 ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: adequate CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt avoids eating snacks, prefers eating breakfast/lunch/dinner SUPPLEMENTS: none RESIDENT EATS: independent ADAPIVE EATNG DEVICES: none MEDICATION: removed for pt privacy MEDICATION WARNINGS [] : no psychotropics NUTRINET TOXCICITY []: no psychotropics

ANTHROPOMETRICS - Ht/Wt: 65” / 321.4lbs [146 kg], Hamwi IBW: 125lbs; 257% IBW [AdjBW appropriate, AdjBW 79kg], BMI:

54 Obesity class 3; UBW: 340lbs

WEIGHT CHANGE: no significant changes

PLANNED Wt CHANGE PROGRAM: [NO]; anticipate future weight changes r/t fluid balance, 1-2# wt loss a wk beneficial w/po intake =/> 70%

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: [hosp] Labs removed date :

Hct/Hgb - [L/L] removed actual values for pt privacy

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [HIGH removed exact for pt privacy] skin intact , bilateral edema (nursing UDA removed date), normal color; ORAL: native teeth, no chewing/swallowing difficulties, oral mucosa moist w/pale hue; MUSCLE WASTING: not evident PHYSICAL ACTIVITY / FUNCTION: mobility: can get out of bed, can move legs/arms, can walk; daily habit: usually sits in chair / occasionally walks OVERALL APPEARANCE: alert/oriented, observable signs of anemia r/t hemorrhage.

CLIENT HISTORY -

AGE: removed gender and age /at birth hospitalized: removed date length of stay: 6d 15hr

PMH: AFIB & CHF

Sx: painful edema and weakness r/t anemia [DI consultation jan 2024]

Hosp Dx: rectal hemorrhage [colonoscopy confirmed], hypokalemia

Providence Dx: acute posthemorrhagic anemia, ABLA (acute blood loss anemia), CHF, hypokalemia, Morbid Obesity

COMPARITIVE STANDARDS / NUTRIENT NEEDS: addresses acute posthemorrhagic anemia, nutritional risk, age, and class 3 obesity; no fluid restriction noted on chart 1/16/24; energy needs w/ AdjBW [79kg]

Est. Kcal Needs: [22 – 25 kcal/kg AdjBW] = 1,738 - 1,975 kcals/d

Est. Protein Needs: [1.0 - 1.2 g /kg AdjBW] = 79 g/d – 95 g/d

Est. Fluid Needs: [25 - 30 ml /kg AdjBW] = 1,738 - 1,975 mL/d

COMMENTS: interview: pt was receptive to consultation. f/u for pt acceptability of supplement.

NUTRITION DIAGNOSIS

1. INCREASED NUTRIENT NEEDS for vit/min r/t rectal hemorrhage & ABLA Please spell this out AEB Dx of acute posthemorrhagic anemia [Low Hgb/Hct, 8.8/28.8].

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; recommend boost DAILY w/ breakfast [preferers: strawberry provides 240 kcals, 10g PRO, 4g Fat], limit/ avoid high sodium foods

INTERVENTION(s)

1. commercial supplement: boost DAILY w/ breakfast

2. Composition of meals: Limit/avoid high sodium meals

NUTRITION EDUCATION [DI consultation jan 2024]: Pt reports wanting to improve edema. Educated pt on importance of her intake

of Vit/Min to improve acute posthemorrhagic anemia. Educated pt that avoiding sodium and balancing their intake across small frequent meals {SFM) may improve/prolong worsening edema; pt was not receptive to SFM but was receptive of decreasing sodium by avoiding asterisked food items on the menu. pt was receptive to drinking strawberry Boost w/breakfast for Nx 1-3. Pt reports restricting sodium.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement intake. See care plan / diet card.

GOAL(s):

1: adequate supplement intake

2: weight stability: preventing unintentional wt loss [wt loss of 1-2#s a wk is beneficial]

3: improved labs (Hgb/Hct): prevent worsening posthemorrhagic anemia

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. =/> 75% po intake of supplement / [progress notes / intake reports]

2. wt stability / [wt reports]

3. labs: Hgb/Hct / [labs]

Contact RDN or DI if any significant changes in wt, po intake, or po supplement intake occur.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 3

Pt screened as at risk for malnutrition due to decreased mobility/po intake, psychological stress r/t surgery, new/worsening illness: MNA [9].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0. ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: varied/not adequate, varied appetite w/stress r/t surgical recovery, avg po </= 50% [pt may be over-reporting intake], hosp noted decreased po intake ranging in 600 kcals – 1800 kcals [physicians note SWEDISH 1/02/24] CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt does not eat snacks, prefers eating small breakfast/lunch/dinner if there is an appetite SUPPLEMENTS: hosp: none RESIDENT EATS: independent ADAPTIVE EATING DEVICES: none MEDICATION: MYLANTA, VITAMIN D3 1000 IU, XARELTO MEDICATION WARNINGS r/t anticoagulant [XARELTO]: [YES] bleeding, anemia, fatigue, hemiparesis, decreased K, decreased platelets, increased alk phos, NUTRIENT TOXICITY r/t anticoagulant [XARELTO]: ginger, garlic, ginseng, grapefruit, vit E food/drink

ANTHROPOMETRICS date - Ht/Wt: 71" / 191.2lbs [87kg], hosp. Wt: 195lbs, Hamwi IBW: 172lbs; 113% IBW [AdjBW N/A] BMI: 26.7 overweight; UBW: 210lbs

WEIGHT CHANGE: - 2% in 3 wks [4lbs] since hosp admit; beneficial slow wt loss

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability, wt loss of 1-2lbs a wk would be beneficial for pt

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: hosp :

GLU mg/dL [H], bedside GLU mg/dL [H], BUN/Cre [H], Ca [L], hgb/hct [ ] [L/L], Na mEq/L [L], mEq/L [L], Phos [H];

providence : WBC [H], RBC [L], hgb/hct [ ] [L/L], MCH [L], MCHC [L], RDW [H], GLU mg/dL, Cre . mg/dL [L], BUN/Cre

[H], Na mmol/L [H] Actual Lab Values removed for Pt protection

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [HIGH], (Comp skin UDA date removed), pale color; ORAL:

no chewing difficulties and gums healthy hue; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily

habit: gets out of bed to use the restroom OVERALL APPEARANCE: oriented/satisfied/complacent SNF change; MUSCLE WASTING:

mild in temples, other muscles and subcutaneous fat appear fine.

CLIENT HISTORY -

AGE: yrs gender removed /at birth hosp admit: date removed length of stay: 5d 22h

Hosp Dx: fracture R femur, surgery, diarrhea, DM,

PMH: DM, other orthopedic joint implants, CHF, AFIB, PVAD, osteoporosis, R hemiplegia/hemiparesis, CVA,. malignant neoplasm of transverse colon, Disease of stomach and duodenum, Atherosclerosis, hyperlipidemia, anemia of chronic disease, Fe deficient anemia, coronary angioplasty, prosthetic heart valve

Sx: pain and diabetic polyneuropathy

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of 1/17; calculated using MSJ w/ AF & IF [ABW 87kg]; addressed CKD/ESRD/PEM/COPD/wound

Est. Kcal Needs: MSJ [1,242 kcals] AF [1] IF [1.1 - 1.3] = 1,615 – 1,815 kcals

Est. Protein Needs: [1.2 - 1.4 g / kg ABW] = 104 g/d – 122 g/d

Est. Fluid Needs: [25 - 30 ml/ kg ABW] = 2,175 - 2,610 mL/d

COMMENTS: Jan 2024 interview: pt was receptive and thankful to consultation, pt was not nervous. f/u to see if pt is developing an appetite, is wt stable, and is satisfied w/food.

NUTRITION DIAGNOSIS

1. INCREASED NUTRIENT NEEDS r/t skeletal trauma, surgery, and altered nutrition related labs AEB Dx:
R femur fractur and hgb/hct [L/L]

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommend 8oz boost plus DAILY w/breakfast [no preference: provides 360kcals, 14g protein, 14g fat], and am/hs snack of [cottage cheese & greek yogurt]

INTERVENTION(s)

1. commercial supplement: 8oz boost plus DAILY w/ breakfast

2. am snack [cottage cheese & greek yogurt]

3. hs snack [cottage cheese & greek yogurt]

NUTRITION EDUCATION [DI consultation Jan 2024]: pt was happy to set a short-term goal to eat snacks as an intervention to develop an appetite. pt agreed to try boost plus for anemia. Educated pt on the importance of their intake of vit/min and food to heal surgical wound. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1: developing an appetite

2: weight stability

3. Improve or postpone worsening anemia of chronic disease

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of supplements/snacks / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

3. monitor hgb/hct / [labs]

Contact RDN or DI if any significant changes in wt, wound healing, po intake, po supplement intake

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 4 ADIME of Case Study Patient

Pt screened as at risk for malnutrition due to decreased mobility/po intake, increased neuropsychological negative experiences/psychological stress, and 3 mo/1 wk Wt loss; MNA [5].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0, avoid/limit high fat/protein foods ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: varied/not adequate, varied appetite w/stress, Pt may eat < 10% of tray, avg PO intake => 66% Cultural preferences discussed. MEALS/SNACK PATTERN: pt avoids eating snacks, prefers eating breakfast/lunch/dinner SUPPLEMENTS: none RESIDENT EATS: independent ADAPIVE EATNG DEVICES: none Medication: Thiamine, FOLIC ACID 1mg, B-COMPLEX; MEDICATION WARNINGS r/t psychotropic [removed name] : anemia, peripheral edema, DM, back pain, dyspnea, asthenia, increased ALP, increased Cre, increased AST, decreased K, decreased platelets NUTRINET TOXCICITY r/t psychotropic [removed name]: grapefruit/alcohol/citrus.

ANTHROPORMETRICS January 2024 - Ht/Wt: 62" / 160.8lbs [73 kg], Hamwi IBW: 110lbs; 146% IBW [AdjBW appropriate, AdjBW 56kg], BMI: 29.4 Overweight; UBW: 110lbs N/A, Pt reported this as being decades ago

WEIGHT CHANGE: 12lbs [7% 1 Wk] r/t decreased PO intake and decreased EDEMA

PLANNED Wt CHANGE PROGRAM: [NO]; anticipate weight changes r/t fluid balance, pt has ascites.

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: [hosp] Labs January :

Hct/Hgb [L/L]; MCV [H]; BUN [L]; AST [H]; providence January 2024 : RBC [L]. hgb/hct [L/L], MCV [H], MCH [H], GLU [H], Cre [H], GFR [L]

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [H] skin intact , 1-2+ pitting edema (Comp skin UDA January), normal color; ORAL: native teeth, no chewing/swallowing difficulties, oral mucosa moist w/pale hue; MUSCLE WASTING: not evident; PHYSICHAL ACIVITY / FUNCTION: mobility: can get out of bed, can move legs/arms, can walk; daily habit: usually stays in bed/ occasionally walks OVERALL APPEANCE: alert/oriented, observable signs of anemia r/t chronic disease

CLIENT HISTORY -

AGE: removed HIPPA yrs

Hx: removed gender/at birth, presented at hospital ED. CT and other exams showed gallbladder distention w/ascites, w/out gallstones, encephalopathy, septicemia gram + cocci / staph [hosp physician note December];

Sx: abdominal pain, back pain, pain w/eating, encephalopathic fever [physicians note December];

Dx: Alcoholism, Depression, Pancreatitis, Cirrhosis, Ascites, Abdominal Pain, Hepatic Encephalopathy, Metabolic Encephalopathy, Thrombocytopenia, Hypocalcemia, MDD, Trunk Epidermis Basal Cell Carcinoma

COMPARITIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction noted on chart. addresses edema/increased eer/catabolic Dxs. calculated MSJ [AdjBW 56kg]

Est. Kcal Needs: MSJ [1,283 kcals] AF [1.3] IF [1.4] = 2,230 - 2,430 kcals/d

Est. Protein Needs: [1.0 - 1.2 g / AdjBW kg] = 56g/d – 67g/d

Est. Fluid Needs: [25 - 30 ml/ AdjBW kg] = 1,400 - 1,680 mL/d

COMMENTS: pt was receptive to consultation. pt was anxious/nervous, educated pt about clergy consultation available for anxiety.

NUTRITION DIAGNOSIS

1. MILD MALNUTRITION [CHRONIC DISEASE] r/t insufficient energy intake, increased nutrient needs, pancreatitis, cancer, and alcoholism AEB < 75% EER > 1mo, pale gums, wt loss 12lbs [7% 1 Wk]

2. DRUG NUTRIENT INTERACTION r/t psychotropic medication [removed name] AEB Pt reports eating citrus fruits and drinks [oranges & orange juice].

3. NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommend high protein boost BID w/ breakfast & dinner [preferers chocolate: provides 240 kcals, 15g PRO, 6g Fat]

INTERVENTION(s)

1. commercial supplement: high protein boost BID w/ breakfast & dinner

NUTRITION EDUCATION [DI consultation January]: Pt reports wanting to lose Wt. Educated Pt on importance of her intake of Vit/Min and food to heal/prevent/prolong worsening anemia of chronic disease. Pt was educated about the drug nutrient interaction with psychotropic; Pt was receptive/thankful of being informed of this interaction and reports not being told about this toxicity by

any other medical professional. Pt was receptive to drinking chocolate Boost w/breakfast.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1. Adequate PO intake

2. weight stability: preventing/postponing unintentional Wt loss

3. limit drug nutrient/ETOH interaction w/ psychotropic

4. improved labs / postpone worsening anemia of chronic disease (K/Ca/Phos, Hgb/Hct, MCV)

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. po intake, =/> 75% of meals/snacks / [progress notes / intake reports]

2. wt stability / [wt reports]

3. decrease po intake citrus / f/u w/pt

4. labs: Hgb/Hct, MCV, K, Ca, Phos / [labs]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake, or skin breakdown occur.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 5

Pt screened as malnourished due to decreased mobility/po intake, psychological stress r/t surgery, Neuropsychological problems r/t Parkinson's. new/worsening illness: MNA [7].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0. ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: varied/not adequate, varied appetite w/stress CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt likes eating snacks, prefers eating small breakfast/lunch/dinner if there is an appetite SUPPLEMENTS: hosp: none RESIDENT EATS: [ASSIST] Set-up ADAPTIVE EATING DEVICES: none MEDICATION: VITAMIN B12 1000 MCG, VITAMIN D3 1000 IU MEDICATION WARNINGS r/t antiparkinson [removed name]: [YES] increased ALP, anorexia, xerostomia, dysphagia, nausea/vomiting, wt fluctuations NUTRIENT TOXICITY r/t antiparkinson [Removed name]: pyrimidine < 5 mg/day, LIMIT fish/whole-grain/chicken/dairy

ANTHROPOMETRICS January - Ht/Wt: 62" / 144lbs [65kg], 1/5/24 hosp. Wt: 142lbs, Hamwi IBW: 110lbs; 130% IBW [AdjBW appropriate, AdjBW 53kg] BMI: 26.2 overweight; UBW: 150lbs

WEIGHT CHANGE: + 1% in 2 wks since hosp admit; beneficial slow wt gain

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability, slow wt loss of 1-2lbs a wk would be beneficial

for pt but not necessary for anemia management

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: hosp January :

BUN [H], Cre [H], WBC [H], BUN/Cre [H], hgb/hct [L/L], ALP [H], MCH [L], MCHC [L]

providence no recent labs as of January 2024

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [H], (Comp skin UDA January), pale color; ORAL: no chewing difficulties and gums pale hue; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily habit: gets out of bed to use the restroom OVERALL APPEARANCE: oriented/satisfied/complacent SNF change; MUSCLE WASTING: no evident muscle/subcutaneous-fat wasting.

CLIENT HISTORY -

AGE: removed HIPPA yrs removed HIPPA /at birth hosp admit: January length of stay: 1 wk

Hosp Dx: ILD w/hypoxia

PMH: DM, CHF, hypertension, CKD [3], parkinsonism, schizoaffective disorder, anemia normocytic, leukocytosis, ARF w/hypoxia, ILD, thrombocytosis

Sx: pain

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of January; [AdjBW 53kg]; addressed CKD/ILD/CHF/ARF

Est. Kcal Needs: [30 – 35 kcals/d AdjBW] = 1,590 – 1,855 kcals/d

Est. Protein Needs: [.8 - 1.2 g / kg AdjBW] = 42 g/d – 64 g/d

Est. Fluid Needs: [ml/ kcal] = 1,590 – 1,855 mL/d

COMMENTS: January 2024 interview: pt was receptive and thankful to consultation, pt was not nervous. f/u to see if pt is wt stable and is satisfied w/food.

NUTRITION DIAGNOSIS

1. ALTERED NUTRITION RELATED LABRATORY VALUES r/t anemia of chronic disease AEB hgb/hct [L/L]

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommend 8oz novasourse DAILY w/breakfast [prefers vanilla: provides 475 kcal, 21.6g protein, 23.8g fat], and encouraged snacks. Novasource to increase nutrient absorption / provide beneficial macronutrients

INTERVENTION(s)

1. commercial supplement: 8oz novasourse DAILY w/breakfast

NUTRITION EDUCATION [DI consultation January 2024]: pt was happy to set a short-term goal to eat snacks and drink a nutritional supplement as an intervention for varied po intake / anemia. Pt on supplements [MCV stable]. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1: adequate po intake

2: weight stability

3. Improve or postpone worsening anemia of chronic disease

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of supplement/meals / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

3. monitor hgb/hct / [labs]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 6

Pt screened as at risk for malnutrition due to decreased mobility/po intake, psychological stress r/t anxiety / MDD, Neuropsychological problems r/t dementia, and new/worsening illness: MNA [6].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0. ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: varied/not adequate r/t dementia CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt does not eat snacks, prefers eating small breakfast/lunch/dinner if there is an appetite SUPPLEMENTS: hosp: none RESIDENT EATS: intermittent to extensive cues/assist ADAPTIVE EATING DEVICES: none MEDICATION: VITAMIN D3 1000 IU MEDICATION WARNINGS r/t psychotropic [ ]: [NO] NUTRIENT TOXICITY r/t psychotropic [ ]: [NO]

ANTHROPOMETRICS January 24 - Ht/Wt: 59" / 111lbs [50kg], 1/11/24 hosp. Wt: 109 bs, Hamwi IBW: 95lbs; 116% IBW [AdjBW N/A] BMI: 22.2 normal; UBW: 115lbs

WEIGHT CHANGE: + 1.8% [2lbs] in 2 wks

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability, wt gain of 1-2lbs a wk would be protective/beneficial for pt r/t age

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: providence January 2024 :

RBC [L], hgb/hct [N/L], MCV [H], MCH [H]; hosp January 2024 : GLU [H], BUN/Cre [H], WBC [H]

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: Braden [10 - 20], blanchable redness increased risk for skin breakdown (Comp skin UDA January 2024), pale color; ORAL: no chewing difficulties and gums pale hue; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily habit: gets out of bed to use the restroom OVERALL APPEARANCE:

anxious/decreased-ability-to-communicate/complacent SNF change; MUSCLE WASTING: severe in temples, buccal/orbital fat pads,

and clavicle; NFPE shows signs of: severe muscle/subcutaneous-fat wasting.

CLIENT HISTORY -

AGE: removed HIPPA yrs Removed gender /at birth hosp admit: January 2024 length of stay: 1wk

Hosp Dx: UTI, Acute cystitis, metabolic encephalopathy,

PMH: Dementia, bladder dysfunction, paraplegia, Parkinson's, hypertension, hyperlipidemia,
anxiety, MDD, scoliosis, osteoporosis, nutritional anemia

Sx: anxiety

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of January 2024; calculated using [ABW 50kg]; addressed age/osteoporosis/acute cystitis

Est. Kcal Needs: [30 – 35 kcal/kg ABW] = 1,500 – 1,700 kcals

Est. Protein Needs: [1 – 1.2 g/kg ABW] = 50 g/d – 60 g/d

Est. Fluid Needs: [30 – 35 mL/kg ABW] = 1,500 – 1,700 kcals

COMMENTS: January 2024 interview: pt was not receptive to consultation r/t dementia/parkinson's. pt was nervous. Pt declines boost intervention. f/u to see if pt is po stable, wt stable, and is satisfied w/food.

NUTRITION DIAGNOSIS

1. SEVERE MALNUTRITION [ACUTE DISEASE] r/t inadequate energy intake, altered consciousness, acute cystitis, severe muscle/subcutaneous-fat-wasting, and altered nutrition related labs AEB < 75% EER for 1 Mo, Dx: dementia / Parkinson's, labs 1/19: MCV 98 [H] / MCH 33.3 [H], Sx: fatigue/nausea w/UTI, NFPE findings of severe indentations of the temples, buccal/orbital fat pads, and clavicles.

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommend 8oz boost plus DAILY w/breakfast [pt refused intervention];

January 2024 pt now accepting protein shake (nutritionally similar to boost) / vitamins from home

INTERVENTION(s)

1. home protein shake (Costco) & vitamins

NUTRITION EDUCATION [DI consultation January 2024]: pt was not oriented, pt has trouble communicating, educated pt on the importance of their intake of vit/min and food to improve macrocytic anemia. f/u to continue pt education

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet

card. Contacted provider re: suspicion of vitamin deficiency r/t malnutrition

GOAL(s):

1: adequate intake

2: weight stability

3. Improve macrocytic anemia

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of meals / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

3. monitor MCH & MCV / [labs]

Contact RDN or DI if any significant changes in wt, wound healing, po intake, po supplement intake

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 7

Pt screened as at risk of malnutrition due to decreased mobility/po intake, psychological stress r/t recent severe injuries: MNA [6].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: easy to chew IDDSI 7/0 ALLERGIES/INTOLERANCES: NFKA APPETITE/PO INTAKE: adequate, decrease in intake of calorically dense food CULTURAL PREFERENCES: discussed MEALS/SNACK PATTERN: pt prefers eating small breakfast/lunch/dinner SUPPLEMENTS: hosp: none RESIDENT EATS: [ASSIST] Set-up ADAPTIVE EATING DEVICES: soups in cups and large straw to sip MEDICATION: MEDICATION WARNINGS r/t factor Xa Inhibitors [ ]: [YES] high AST, high ALT, anemia, decreased platelets, subdural hematoma NUTRIENT TOXICITY r/t factor Xa Inhibitors [ ]: [YES] anticoagulants ginger, ginseng, garlic, grapefruit, and citrus

ANTHROPOMETRICS 1/ /24 - Ht/Wt: 71" / 181.2lbs [82kg], 12/ /23 hosp Wt: 201lbs, Hamwi IBW: 172lbs; 105% IBW [AdjBW N/A], BMI: 25 normal, UBW: 215lbs *had to ask pt Ht, it was recorded incorrectly in the system 1/30

WEIGHT CHANGE: 9.9% wt loss in 1 mo [20lbs] r/t decreased po intake with neck trauma

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability, avoiding unintentional wt loss

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: providence 1/26/24:

RBC [L], hgb/hct [L/L], GLU mg/dL [H], Cre [L], BUN/Cre [H], no hosp labs as of 1/25/24

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: no edema noted, healthy skin tone, Braden [H], surgical wound 2x posterior neck and back 2x surgical wound r/t injury (Comp skin UDA JAN); ORAL: teeth intact but chewing difficulties r/t neck surgery, no swallowing difficulties, and oral mucosa healthy hue; PHYSICAL ACIVITY / FUNCTION: mobility: does not get out of bed daily habit: bedbound; OVERALL APPEARANCE: nourished/oriented/satisfied/complacent SNF change; MUSCLE WASTING: no signs of muscle / subcutaneous fat wasting

CLIENT HISTORY -

AGE: yrs gender /at birth hosp admit: 1/ /24 length of stay: 3 Wk

Hosp Dx: neck fracture and stable burst fracture of T11-T12 vertebra

PMH: CAD, AFIB, hyperlipidemia, hypertension

Sx: pain/weakness/

COMPARATIVE STANDARDS / NUTRIENT NEEDS*:* no fluid restriction in chart as of 1/25; [ABW 82kg]; addressed skeletal trauma/Age

Est. Kcal Needs: [25 – 30 kcals/kg ABW] = 2,050 – 2,460 kcals/d

Est. Protein Needs: [1.2 - 1.5 g/kg ABW] = 98 g/d – 123 g/d

Est. Fluid Needs: [ml/ kcal ABW] = 2,050 – 2,250 mL/d

COMMENTS: 1/ /24 interview: pt was receptive and thankful for consultation. pt very aggregable with drinking health shakes and nutritional supplements to heal from surgery. f/u to see if pt is wt stable / satisfied w/food.

NUTRITION DIAGNOSIS

1. INCREASED NUTRIENT NEEDS r/t surgery and altered nutrition related labs AEB Dx: neck fracture, stable burst fracture of T11/T12
vertebra, and hgb/hct 11.9/35.7 [L/L]

NUTRITION Rx PRESCRIPTION: easy to chew IDDSI 7/0 w/ extra sauce/gravy ; Recommend 8oz health shake BID

w/breakfast/dinner [prefers vanilla/chocolate; provides 638 kcal, 26g protein, 30g fat], and active liquid protein for wound

healing BID w/lunch & pm snack with water / beverage of choice [no preference: provides 160 kcals, 36g protein, 0g fat]

INTERVENTION(s)

1. facility in-house supplement: 8oz health shake BID w/breakfast/dinner

2. medical food: 30mL active liquid protein with water / beverage of choice

NUTRITION EDUCATION [DI consultation 1/ /24]: pt was happy to set a short-term goal to drink health shakes BID and active liquid protein as an intervention for faster skeletal healing. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1. wound healing

2. weight stability

3. improved anemia

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. wound healing / [progress notes]

2. wt stability / no unintentional wt loss / [wt reports]

3. improved anemia / [labs hgb/hct]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 8

Pt screened as malnourished due to decreased mobility/po intake, psychological stress/anxiety r/t CVA hemiplegia/hemiparesis w/dysphagia, new/worsening illness: MNA [5].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: IDDSI 7 easy to chew / 0 thins. ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: not adequate, no appetite r/t anxiety w/eating </= 50% EER 1 mo CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt likes eating snacks, prefers eating small breakfast/lunch/dinner if there is an appetite SUPPLEMENTS: hosp: none RESIDENT EATS: [ASSIST] dependent 1:1 upright ADAPTIVE EATING DEVICES: none MEDICATION: MEDICATION WARNINGS r/t antihypertensive [ ]: [YES] increased K, increased VLDL, decreased HDL, depression, and confusion NUTRIENT TOXICITY r/tantihypertensive [ ]: [YES] licorice

ANTHROPOMETRICS 1/25/24 - Ht/Wt: 67"/ 157lbs [71kg], 1/22/24 hosp. Wt: 170lbs, Hamwi IBW: 135lbs; 116% IBW [AdjBW N/A] BMI: 24.5 ; UBW: 180lbs

WEIGHT CHANGE: - 7.6% in 1 wk [13lbs]

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: providence 1/26/24:

GLU 100 mg/dL [H] hosp 1/25/24 : Cre .71 [L], Mg 2.4 [H];

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: no edema noted, pale color, Braden [17], facial droop w/ bruise on left arm (Comp skin UDA 1/23); ORAL: possible broken tooth noted (Nursing UDA 1/23), gums pale hue, moderate chewing/swallowing problems r/t CVA (patient reports that this is improving 1/19); PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily habit: bedbound OVERALL APPEARANCE: oriented/nervous/underweight/satisfied/complacent SNF change; MUSCLE WASTING: mild muscle/subcutaneous-fat wasting in temples/buccal-fat-pads

CLIENT HISTORY -

AGE: yrs gender /at birth hosp admit: 1/ /24 length of stay: 1 mo

Hosp Dx: CVA

PMH: hemiplegia/hemiparesis, aphasia w/CVA, dysphagia, hypertension, rheumatoid arthritis, anxiety, OCD, GERD

Sx: pain, numbness right side of body

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of 1/25; [71kg]; addressed CVA

Est. Kcal Needs: [35 – 40 kcals/kg ABW] = 2,485 – 2,840 kcals/d

Est. Protein Needs: [1.2 - 1.5 g / kg ABW] = 85 – 107 g/d

Est. Fluid Needs: [30 - 35 ml / kg ABW] = 2,130 – 2,485 mL/d

COMMENTS: 1/ /24 interview: pt was receptive and thankful to consultation, pt was not nervous; but it was evident that pt was nervous about chewing food r/t stroke. f/u to see if pt is wt stable and is satisfied w/food.

NUTRITION DIAGNOSIS

1. SEVERE MALNUTRITION [ACUTE ILLNESS] r/t CVA and decreased po intake AEB 7.6% wt loss in 1 wk, </= 50% EER 1 mo

NUTRITION Rx PRESCRIPTION: IDDSI 7 easy to chew / 0 thins; Recommend 8oz health shake BID w/breakfast/dinner [prefers chocolate:provides 638 kcal, 26g protein, 30g fat]

INTERVENTION(s)

1. facility in-house supplement: 8oz health shake BID w/breakfast/dinner

NUTRITION EDUCATION [DI consultation 1/ /24]: pt was happy to set a short-term goal to develop an appetite by drinking a nutritional supplement as an intervention for varied po intake causing wt loss. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1. adequate po intake

2. weight stability

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of meals >/= 90% supplement / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 9

INITIAL NUTRITION ASSESSMENT

Pt screened as malnourished due to decreased mobility/po intake, psychological stress r/t recent fall

and severe injuries: MNA [5].

Nutrition Assessment

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: IDDSI 7 easy to chew / 0 thins ALLERGIES/INTOLERANCES: Fish/Shrimp/Egg/Chicken/Beef/Turkey APPETITE/PO INTAKE: not adequate, no appetite w/stress/abdominal pain CULTURAL PREFERENCES: discussed MEALS/SNACK PATTERN: pt does not eat snacks, prefers eating small breakfast/lunch/dinner if there is an appetite, pt also receives food from daughter 4X - 5X wk SUPPLEMENTS: hosp: none RESIDENT EATS: [ASSIST] Set-up ADAPTIVE EATING DEVICES: none MEDICATION: MEDICATION WARNINGS r/t factor Xa Inhibitors [ ]: [YES] high AST, high ALT, anemia, decreased platelets, subdural hematoma NUTRIENT TOXICITY r/t factor Xa Inhibitors [ ]: [YES] anticoagulants ginger, ginseng, garlic, grapefruit, and citrus

ANTHROPOMETRICS 1/19/24 - Ht/Wt: 60" / 121lbs [55kg], 1/11/24 hosp Wt: 141lbs, Hamwi IBW: small frame 90lbs; 134% IBW [AdjBW 44kg], BMI: 23.6 normal, UBW: 150lbs

WEIGHT CHANGE: - 14% in 2 wks [20lbs] since hosp admit; r/t decreased po intake / abdominal pain

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability, avoiding unintentional wt loss

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: hosp 1/ /24 :

MCH [H], MCHC [H], PLT [L], AST [H]; providence no recent labs as of 1/30/24

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: pale color for darker skin tone, Braden [18], bruises/edema L knee r/t fall, laceration right upper forehead r/t fall (Comp skin UDA 1/23); ORAL: chewing difficulties r/t no native teeth w/o dentures, gums pale hue; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily habit: sometimes gets out of bed to use the restroom OVERALL APPEARANCE: malnourished/oriented/satisfied/complacent SNF change; MUSCLE WASTING: moderate muscle/subcutaneous-fat wasting in temples/buccal-fat-pads

CLIENT HISTORY -

AGE: yrs gender /at birth hosp admit: 1/ /24 length of stay: 2 wk

Hosp Dx: fracture left radius, fracture left ulna, head laceration/contusion, fall,

PMH: CVA w/hemiparesis, AFIB, hypertension, hyperlipidemia

Sx: pain/weakness/abdominal pain w/eating

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of 1/23; [ABW 44kg];

addressed skeletal trauma/Age

Est. Kcal Needs: [35 – 40 kcals/d ABW] = 1,540 – 1,760 kcals/d

Est. Protein Needs: [1.2 - 1.5 g/kg ABW] = 53 g/d – 66g/d

Est. Fluid Needs: [30 – 35 ml/ kcal ABW] = 1,320 – 1,540 mL/d

COMMENTS: 1/24/24 interview: pt was receptive and thankful to consultation, spoke to pt's daughter. f/u to see if pt is wt stable / satisfied w/food.

NUTRITION DIAGNOSIS

1. SEVERE MALNUTRITION [ACUTE ILLNESS] r/t wt loss and decreased po intake AEB 14% wt loss in 2wks, </= 50% EER for 1 mo, and mild muscle/subcutaneous fat wasting in the temples/buccal-fat-pads

NUTRITION Rx PRESCRIPTION: IDDSI 7 easy to chew / 0 thins; Recommend 8oz health shake BID w/breakfast/dinner

[prefers vanilla; provides 638 kcal, 26g protein, 30g fat]

INTERVENTION(s)

1. facility in-house supplement: 8oz health shake BID w/breakfast/dinner

2. give meds w/ house shake or yogurt if she will accept, avoid giving w/water on empty stomach

NUTRITION EDUCATION [DI consultation 1/ /24]: pt was happy to set a short-term goal to drink health shakes BID as an intervention for skeletal healing / recent wt loss. Consulted w/daughter about pt's drug nutrient toxicity w/herbs. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE: notified nursing of importance of supplement/snack intake. See care plan / diet card. Talked to nurse about giving medication w/house shake and/or yogurt.

GOAL(s):

1. adequate po intake

2. weight stability

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of meals >/= 90% supplement / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG

ADIME 10

Pt screened as at risk of malnutrition due to decreased mobility/po intake, psychological stress r/t surgery/sepsis,

new/worsening illness of sepsis : MNA [8].

INITIAL NUTRITION ASSESSMENT

FOOD/NUTRITION RELATED HISTORY - DIET ORDER: regular IDDSI 7/0 ALLERGIES/INTOLERANCES: NKFA APPETITE/PO INTAKE: not adequate no appetite r/t stress/surgery, </= 75% EER >/= 1 mo [RD note 12/22/23] CULTURAL PREFERENCES: discussed. MEALS/SNACK PATTERN: pt tries eating small breakfast/lunch/dinner if there is an appetite SUPPLEMENTS: hosp: none RESIDENT EATS: Independent ADAPTIVE EATING DEVICES: none MEDICATION: MEDICATION WARNINGS r/t antidepressant [ ]: [NO] NUTRIENT TOXICITY r/t antidepressant [ ]: [NO]

ANTHROPOMETRICS 1/ /24 - Ht/Wt: 71" / 205lbs (93kg), 1/19 hosp. Wt: 174lbs inaccurate 12/ /23 hosp Wt: 215lbs Hamwi IBW: 172lbs; 119% IBW [AdjBW N/A] BMI: 28 overweight; UBW: 240lbs

WEIGHT CHANGE: facility = 5% wt loss in 1 mo; hospital = > 5% wt loss in 1 mo [RD note 12/ /23]

[H&P wt change 12/ /23 238lbs - 12/ /23: 241lbs - 12/ /23: 224lbs]

PLANNED Wt CHANGE PROGRAM: [NO]; focusing on wt stability / preventing further unintentional wt loss

BIOCHEMICAL DATA, MEDICAL TESTS & PROCEDURES: providence 1/ /24:

RBC [L], hgb/hct [L/L], MCH [L], MCHC [L]; hosp 1/ /24 : WBC [H]

NUTRITION-FOCUSED PHYSICAL EXAM FINDINGS - SKIN: no edema noted, good skin hue, Braden [19], coccyx stage II pressure injury, surgical incision lower back (Comp skin UDA 1/ /24); ORAL: no chewing/swallowing difficulties, gums a good hue; PHYSICAL ACIVITY / FUNCTION: mobility: can get out of bed w/assistance daily habit: gets out of bed to use the restroom OVERALL APPEARANCE: possible edema in cheeks / nourished appearance misleading / oriented / satisfied / complacent SNF change; MUSCLE WASTING: mild subcutaneous fat wasting in buccal fat pads.

CLIENT HISTORY -

AGE: yrs gender /at birth hosp admit: 11/ /2023 length of stay: 4 mo

Hosp Dx: laminectomy/discectomy, nosocomial infection, bacteremia, sepsis, pneumonia

PMH: osteomyelitis, lumbar discitis, CKD [3], lumbar radiculopathy, AFIB, hyperlipidemia

Sx: pain

COMPARATIVE STANDARDS / NUTRIENT NEEDS: no fluid restriction in chart as of 1/24; [ABW 93kg];

addressed CKD/stage II Pressure Injury

Est. Kcal Needs: [25 – 30 kcals/d ABW] = 2,325 – 2,790 kcals/d

Est. Protein Needs: [1.2 - 1.3 g/kg ABW] = 112 g/d – 121 g/d

Est. Fluid Needs: [ml/ kcal ABW] = 2,325 – 2,790 mL/d

COMMENTS: 1/ /24 interview: pt was receptive/thankful for consultation, pt was not nervous. f/u to see if pt is wt stable and is satisfied w/food.

NUTRITION DIAGNOSIS

1. MODERATE MALNUTRITION [ACUTE DISEASE] r/t sepsis, decreased po intake, and altered nutrition related labs AEB 5% wt loss in 1 mo, </= 75% EER > 1 mo, hgb/hct [L/L]

NUTRITION Rx PRESCRIPTION: regular IDDSI 7/0; Recommend 30mL active liquid protein mixed w/beverage of choice BID w/breakfast/dinner [no preference: provides 160 kcals, 36g protein, 0g fat]

INTERVENTION(s)

1. medical food: 30mL active liquid protein BID w/ water or beverage of choice

NUTRITION EDUCATION [DI consultation 1/ /24]: pt was happy to set a short-term goal to try and eat snacks and eat more mealsto increase appetite. pt agreed to drink an active liquid protein BID as an intervention for stage II pressure ulcer. Wt loss r/t not having an appetite while at the hospital. f/u to record pt acceptability of interventions.

COORDINATION OF NUTRITION CARE*:* notified nursing of importance of supplement/snack intake. See care plan / diet card.

GOAL(s):

1. adequate po intake

2. wt stability

3. improved anemia

NUTRITION MONITORING AND EVALUATION

INDICATOR(s) / CRITERIA:

1. >/= 50% po intake of meals >/= 90% PO intake of supplements / [progress notes / intake reports]

2. wt stability / no unintentional wt loss / [wt reports]

3. improved hgb/hct / [labs hgb/hct]

Contact RDN or DI if any significant changes in wt, po intake, po supplement intake.

Written By:

` ~ ` Samantha Walton Dietetic Intern ` ~ `

Cosigned by Jane Clements RDN , CD, CSG