Nutritional Risk Review/Nutrition Intervention Team

POLICY

Residents with unplanned weight changes, new malnutrition diagnosis, open skin ulceration, dehydration, tube feedings, TPN, fecal impaction, or other identified nutritional problems will be reviewed by an interdisciplinary team in a timely manner and interventions will be instituted to correct the nutritional concern.

PROCEDURE

Weights are obtained on each resident on a weekly or monthly basis based on their assessed needs. If no alternate weighing system is in place, the facility will follow procedure number 2-4 below.

All residents with +/- 3# change will be reweighed within 48 hours of the questionable weight.

All weights will be reviewed by the charge nurse or designated nursing personnel prior to documenting in the medical record. Weights that are found to be erroneous (based on reweights) will not be documented in the chart.

If a resident is unable to be weighed due to extenuating circumstances, their nutritional status will be monitored using other measures including laboratory review, meal monitoring and progress with wound healing, if applicable.

The nutrition committee coordinator (usually dietitian or DSM) reviews weights and meal and fluid documentation each week.

The committee coordinator calculates 30-day, 90-day and 180-day weight changes for each resident and compiles a list of all residents with significant weight variances. Additionally, residents with undesired downward trends in their weight and/or recent decline in their meal intake or frequent meal refusals should be included on this list.

A nutritional risk review committee consisting of the DNS or designated nursing representative(s), dietitian or DSM, social services director, restorative nursing representative, wound nurse, activities personnel, nursing assistants and speech or occupational therapist, as able, will meet weekly to review the residents identified with nutritional concerns.

All residents with unstable nutritional status, including weight change, inadequate oral intake, poorly controlled diabetes, tube feeding, TPN/PPN, dehydration, fecal impaction, dialysis, St II-IV pressure ulcers or other nutritional conditions will be reviewed by the committee weekly or at a frequency determined by the clinical team based on the residents needs. If a resident has experienced a weight change that is determined to be strictly due to fluid shifts (changes in edema or large volumes of IV fluids administered prior to admission) and their intake meets estimated needs since admission, a note to this effect can be made in the clinical record and the *Nutrition Risk Review* form need not be completed.

The committee coordinator will provide written communication to the team members at least 2 working days prior to the nutritional risk meeting date. This communication will reflect the meeting date and time as well as the list of residents to be reviewed.

For all newly identified residents with nutritional concerns of **weight loss, pressure sores, open wounds, or dehydration**, a *Nutritional Risk Review* form will be placed under the dietary section of their medical record on the same day the written communication is sent to the team members. Nursing, social services, dietary (and possibly ST/OT) will be responsible for completing their section of the form prior to attending the scheduled meeting. Each team member is also asked to come prepared with at least one possible intervention to try for each resident being reviewed. Responsibilities include:

*Nursing/Medical Assessment section of the form includes a review of any diagnosis or change in medical status that may have an effect on the residents' nutritional status. Areas including fluid retention, pain, positioning, oral status and communication are to be assessed. Each resident should be observed in the dining room prior to coming to the meeting. The comment/intervention section should include a general nursing assessment as well as at least one planned intervention.

*Social Services Assessment includes a review of the residents' psychosocial status, being descriptive about any signs of depression, behaviors, etc. that could negatively effect the residents' nutrition. A special focus should be placed on if the resident has medical directives re: nutrition and hydration approaches. A question is included in this section regarding the residents' activities or socialization. The SS personnel should ask the activities personnel to complete this question or should consult with them prior to documenting in this area. The comment/intervention section should include a general assessment of the residents' psychological status as well as at least one possible approach to assist with improved nutritional status.

*Dietary Assessment section includes weight data, diet and supplement information, dining services issues, food preferences, calculation of nutrition and hydration requirements and abnormal labs that could indicate a nutritional concern. All residents being assessed should be observed during a meal prior to completing this form and information from that observation recorded in this section. A general nutritional assessment should be completed at the bottom and at least one planned intervention documented.

*Several questions on the form are noted to have a * or ** next to them. These are questions that may trigger the person doing the assessment to refer to speech* or occupational therapy** if there is a concern in these areas.

The team members meet as a group weekly to discuss their respective findings and a team conclusion with interventions is written. Additionally a care plan is developed or updated to include the nutritional problem, goal and approaches discussed. The bottom of the form is to be completed in its entirety. The team needs to include a discussion of whether a significant change in condition has occurred for the resident and if need be, refer for a new MDS. (A significant change in condition is defined as a change in 2 or more areas – one may be weight loss of 5% in 30 days or 10% in 180 days. Please refer to the RAI manual for further details.) Each team member attending the meeting should sign the summary section of the form for the resident reviewed.

Each resident reviewed by the committee is followed for a period of time after his or her nutritional status has stabilized, based on the discretion of the team. The back of the *Nutritional Risk Review* form allows for follow up documentation. Additional documentation can be completed on copies of this back page, kept in the chart with the original form. The follow up review completed for each resident should include a review of the last sessions notes and whether the approaches were successful, current weight and intakes and change from previous review, new medical concerns, new social concerns, at least one new intervention (if the resident is not improving), and when the next review will be completed for this resident. Residents with nutritional problems including **significant weight gain, dialysis, tube feeding, TPN, fecal impaction and thickened liquids** do not need to have the full front page assessment completed but should be monitored using the follow up review form.. When the committee feels that high-intensity observation is no longer necessary, the resident can be discontinued from the review.

The *Nutritional Risk Review* forms should be kept in the residents' medical record for at least one year.

The committee coordinator is responsible for:

*Getting the list of residents to the committee members in established timeframes
*Bringing all charts to the meeting and returning them when completed
*Insuring the meeting starts on time and is run efficiently and without interruption
*Assigning duties to be completed during the meeting – to include:
>Documenting on the *Nutritional Risk Review* form
>Keeping minutes and assignments
>Writing referral forms, fax requests or telephone orders
>Updating the care plan
>Scanning the chart, weight log, and meal monitor for any items needed
>Time monitoring (goal 5 minutes per resident)
*Insuring all forms are completed in their entirety
*Reporting to administrator any concerns regarding the committee