Nutritional Screening Questions, Risk Assessment and Management Plan

All patients to be screened: on admission, transfer to another ward, if the condition changes, then weekly

Does the patient have any food allergies? YES/ NO (please circle) **If YES name/s of allergen/s**: _____

Does the patient require a special diet not available on the menu? YES/ NO If yes Refer to dietitian Date referred: ____ /__ _/_____

Consider referral to speech and language if the patient has a swallowing problem

Screening Questions (highlighted in blue circle as applicable)	**Initial Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
Have you lost weight in the last 3 months (unintentionally)?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Are you underweight?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Have you got any problems with your appetite/ eating & /or drinking?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Known dementia or a delirium?	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Visual impairment/blind?(E.g glaucoma/ macular degeneration/cataracts)	**YES / NO**	**YES / NO**	**YES / NO**	**YES / NO**
Weight on each assessment & Height on initial assessment:	**Kg M**	**Kg**	**Kg**	**Kg**
Rationale if not weighed:				
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:
Ward:	Ward:	Ward:	Ward:	Ward:
Signature:	Sign:	Sign:	Sign:	Sign:

Full Nutritional Risk Assessment Complete this section if answered '**YES**' to any of the screening questions **Circle the highest score in each section**	**Initial Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
Weight loss in last 3 months				
No weight loss	0	0	0	0
0-3Kg (0-7lb) weight loss	1	1	1	1
>3-6Kg (7-14lb) weight loss	2	2	2	2
6Kg (14lbs or more) weight loss	3	3	3	3
BMI (Body Mass Index – calculate from weight and height using BMI chart				
20 or more (normal weight or above) (mid upper arm circumference >23.5cm)	0	0	0	0
18-19 (slightly underweight) (mid upper arm circumference 21.1-23cm)	1	1	1	1
15-17 (moderately underweight) (mid upper arm circumference 20.1-21cm)	2	2	2	2
Less than 15 (severely underweight) (mid upper arm circumference <20cm)	3	3	3	3
Appetite				
Good appetite - manages most of 3 meals per day or equivalent)	0	0	0	0
Poor appetite/ intake - leaving > half of meals provided (or equivalent)	2	2	2	2
Appetite nil or virtually nil - unable to eat /NBM (for >4 meals)	3	3	3	3
Ability to Eat /Retain Food /Hydration State				
No difficulties eating or drinking (able to eat independently/tolerating enteral feeds/no diarrhoea / no vomiting/ well hydrated)	0	0	0	0
Problems handling food e.g. needs special cutlery/confused **Vomiting/ Regurgitation/ Mild diarrhoea**	1	1	1	1
Difficulty swallowing – requires modified consistency **Problems with dentures or chewing affecting food intake** **Problems tolerating enteral feeds** **Moderate vomiting and /or diarrhoea** (1-2 days) **Needs help with feeding** (e.g. physical handicap)	2	2	2	2
Unable to take food orally / Unable to swallow (complete dysphagia) **Severe vomiting and/or diarrhoea >2 days** **Malabsorption/ Dehydration** **Psycho-social problems reducing food intake**	3	3	3	3
Stress Factor				
No stress factor includes admission for investigation only	0	0	0	0
Mild Minor surgery/ Minor infection/ CVA	1	1	1	1
Moderate Chronic disease/ Major surgery/ Infections / Fractures/ Pressure ulcers/ Inflammatory bowel disease/ Other gastro intestinal disease/Heart failure	2	2	2	2
Severe Multiple injuries/multiple fractures/burns/ Multiple pressure ulcers/Severe sepsis/ Carcinoma/ Malignant disease	3	3	3	3
TOTAL:				
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:
Ward:	Ward:	Ward:	Ward:	Ward:
Signature	Sign:	Sign:	Sign:	Sign:

Total Score 0-3	**Action: repeat score weekly/on transfer /or change of condition**
Total Score 4-5	**Action: Commence Nutrition Management Plan, consider referral to Speech & Language Therapy**
Total Score 6-15	**Action: Commence Nutrition Management Plan, refer to dietitian, consider referral to Speech & Language Therapy**

NUTRITION MANAGEMENT PLAN						
Commence Nutrition Management plan for patients with a score of 4 or more						
Risk	Plan	Action	Date	Date	Date	Date
	Weight – mandatory *Use hoist or seated scales if required*	State Weight	Kg	Kg	Kg	Kg
	Repeat Risk score weekly - mandatory	Risk score				
	Commence food chart- mandatory	Tick ✓				
	Provide a red tray - mandatory	Tick ✓				
	Does the patient require assistance to eat?	YES/NO				
	Does the patient require adapted cutlery? *Consider the need for specialist cutlery using OT flowchart*	YES/NO				
	Does the patient require supervision when eating?	YES/NO				
	Offer snacks or supplements to replace missed meals - mandatory	Tick ✓				
	Identify preferred foods if necessary	Document preferred foods				
	Contact catering to discuss availability of preferred food if necessary	Enter date catering contacted				
HIGH	**REFER TO DIETITIAN***	Time & Date				
	Consider a referral to Speech and Language (SLT) if patient has swallowing problems	Enter time and date of referral				
	If nasogastric tube in situ commence checklist and care plan	Enter time date commenced				
		Signature:				

To refer a patient to a dietitian: all referrals should be made electronically via the electronic handover system. If you require urgent assistance please contact the dietetic department on Ext. 42673 BHH Ext 45127 SH, Ext. 40759 Elderly Medicine, BHH or Ext. 47768 GHH in addition to making the referral electronically.

To refer a patient to SLT: leave a message on Ext 40432 BHH or Ext 44126 SH, or Ext 42778 Elderly Medicine, BHH or Ext 47056 GHH. **Patients will be seen within 2 working days of referral**

*** Also refer to the dietitian if the patient needs a special diet that is not available on the normal menu or if the patient needs advice about a special diet**