A.S.P.E.N. ADULT NUTRITION CARE PATHWAY
(Age 18+ years)

ADMISSION
- Obtain actual, measured height/weight and BMI and document on admission
- Validated screening tool completed
  • Screen completed in 24 hours
  • Results documented in EMR
- Physician consult on admission

SUSPECTED MALNUTRITION?
- Yes
  - GENERATE NUTRITION CONSULT
    - Via EMR, automatic trigger or documented in MR
  - NUTRITION ASSESSMENT [RD, NST]
    - Completed within 24 hours of consult
      • Food and Nutrition History
      • Anthropometrics
      • Biochemical data/Medical Tests & Procedures
      • Nutrition Focused Physical Exam (NFPE)
      • Clinical and Medical History
  - MALNUTRITION DIAGNOSIS/RISK DOCUMENTED [RD, NST, RN, MD/NP/PA]
    • RD documents malnutrition risk status
    • RD documents supporting evidence of malnutrition severity
    • MD documents malnutrition and severity in progress note and adds to problem list

- No
  - FOLLOW UP/RESCREEN [RD, NST, DT, OR DESIGNEE]
    • Every 3-7 days to prevent hospital-acquired malnutrition
    • Based on length of stay
    • Upon transition of care

MALNUTRITION IDENTIFIED?
- Yes
- NO

MORE ON NEXT PAGE
NUTRITION CARE PLAN AND INTERVENTION
[RD, NST, RN, MD/PA/NP, PharmD]
- Nutrition care plan created & documented; goals identified
- Initiate order/identify type of nutrition support required
  - Provide least restrictive, medically appropriate diet
  - Determine need for nutritional supplementation
  - Treatment of medical issues impacting nutrition intake and utilization
- Determine access needs for specialized nutrition support to maximize nutritional intake (Enteral feeding tubes, IV access for PN)
  - Review medications regarding impact on nutritional intake
- Communicate nutrition care plan with team members on multidisciplinary patient care rounds
- Educate patient/caregiver regarding plan of care.

MONITORING & EVALUATION
[RD, NST, RN, MD/PA/NP, PharmD, PT, OT]
- Follow-up within 3 days
- Monitoring parameters
  - Tolerance of nutrient intake
  - Oral intake including supplements, vitamins, minerals
  - Enteral/Parenteral intake
  - Anthropometric data (weight trends)
  - Biochemical data
  - Functional status

REVISE NUTRITION CARE PLAN

DOCUMENT PARAMETERS THAT INDICATE IMPROVEMENT IN NUTRITION STATUS
[RD, PT, OT]
- Adequate nutrient intake
- Stable or increased weight
- Stability of biochemical data
- Improved strength and function

CONTINUE CURRENT NUTRITION CARE PLAN
- Reassess every 3-5 days
- Begin discharge planning

DISCHARGE PLAN
[RD, RN, MD/PA/NP, PharmD, CM]
- Education / Counseling with patient and caregivers
- Communication of PN, EN or Oral Nutrition Supplement prescription
- Case management for continuity of care
- Outpatient follow-up as appropriate

KEY
- Action Steps
- Documentation Steps
- Communication Steps
- RN Registered Nurse
- RD Registered Dietitian
- DT Diet Technician
- NFPE Nutrition Focused Physical Exam
- NST Nutrition Support Team
- MD Medical Doctor
- NP Nurse Practitioner
- PA Physician Assistant
- PharmD Pharmacist
- CM Case Manager
- OT Occupational Therapist
- PT Physical Therapist
- AND Academy of Nutrition and Dietetics
- A.S.P.E.N. American Society for Parenteral and Enteral Nutrition
- PN Parenteral Nutrition
- EN Enteral Nutrition
- NPO/CLD Nothing by Mouth/Clear Liquid Diet
- EMR/MR Electronic Medical Record or Medical Record
- BMI Body Mass Index

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