ASPEN ADULT NUTRITION CARE PATHWAY
(Age 18+ years)

ADMISSION SCREENING
- Measure and document actual height and weight
- Complete validated screening tool within 24 hours and document in EHR

MALNUTRITION SUSPECTED?

GENERATE NUTRITION CONSULT
RD notified by automated trigger in EHR or by consult

NUTRITION ASSESSMENT
Completed by RD or NST within 24 hours of nutrition risk identification
- Clinical and medical history
- Food and nutrition history
- Anthropometrics
- Biochemical data/medical tests and procedures
- Nutrition focused physical exam (NFPE)

MALNUTRITION IDENTIFIED?
AND/ASPEN malnutrition characteristics

DOCUMENT MALNUTRITION DIAGNOSIS
- RD documents malnutrition risk status
- MD/DO/NP/PA and RD document supporting evidence of malnutrition severity
- MD/DO/NP/PA and RD document malnutrition and severity in progress note and add to problem list

CODE MALNUTRITION DIAGNOSIS
- Notify coder of diagnosis
- Use adult malnutrition codes

CONTINUED ON NEXT PAGE
NUTRITION CARE PLAN AND INTERVENTION
[RD, NST, RN, MD/DO/NP/PA, RPh/PharmD]

- Create and document nutrition care plan with goals identified
- Initiate order/identify type of nutrition support required
  - Provide least restrictive, medically appropriate diet
  - Determine need for nutrition supplementation
  - Treat medical issues impacting nutrition intake and utilization
- Determine access needs for specialized nutrition support to maximize nutrition intake (enteral feeding tubes for EN, IV for PN)
  - Review medications regarding impact on nutrition intake
- Communicate nutrition care plan with team members on interdisciplinary patient care rounds
- Educate patient/caregiver regarding plan of care

MONITORING & EVALUATION
[RD, NST, RN, MD/DO/NP/PA, RPh/PharmD, PT, OT]

- Follow-up within 3 days
- Monitor parameters
  - Tolerance of nutrient intake
  - Oral intake including supplements, vitamins, minerals
  - Enteral/parenteral intake
  - Anthropometric data (weight trends)
  - Functional status

IMPROVEMENT IN NUTRITION STATUS?
DOCUMENT PARAMETERS THAT INDICATE IMPROVEMENT

- 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 in acute care setting, as needed in home and long-term care
- Begin discharge planning

DISCHARGE PLAN
[RD, RN, MD/DO/NP/PA, RPh/PharmD, CM]

- Educate/counsel patient and caregivers
- Communicate current nutrition assessment and care plan
- Communicate PN, EN or oral nutrition supplement prescription and supplies
- Involve case management or social services for continuity of care
- Provide ongoing follow-up as appropriate

REVISE NUTRITION CARE PLAN

NO

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/DO Physician
NP Nurse Practitioner
PA Physician Assistant
RPh/PharmD Pharmacist
CM Case Manager
OT Occupational Therapist
PT Physical Therapist
AND Academy of Nutrition and Dietetics
PN Parenteral Nutrition
EN Enteral Nutrition
EHR Electronic Health Record