

# NCP 2023 Tutorial

## Module 3 Transcript

In this NCP tutorial, Module 3, the objectives are to one, understand the purpose of Nutrition Assessment, and two, understand the components of Nutrition Assessment, including the Nutrition Assessment terminology as well as the comparative standards used to evaluate assessment data.

The first step in the Nutrition Care Process is the Nutrition Assessment as shown by the white arrow in the graphical model on the right. It is important to conduct a thorough Nutrition Assessment as it serves as the basis for the rest of the process. The purpose of the Nutrition Assessment is to collect, classify and synthesize relevant data and use collected data as evidence to identify and prioritize a nutrition related problem or problems. This step requires critical thinking skills, which may include being able to determine what data is important and relevant, being able to determine the need for additional information to make an informed decision, to select the appropriate assessment tools and procedures that match the current situation, the ability to apply tools in a valid and reliable way and understand how to validate data. This step also includes reassessment for comparing and reevaluating data from a previous assessment. The purpose is to identify whether previously collected data has changed and to determine if previously identified nutritional problems have changed. We will use these common nutrition status terms new, active, resolved or discontinued problems.

There are many different sources of nutrition assessment data, and the type of data that you will use in your assessment really depends on the situation that you're in. Data for an inpatient setting might look quite different than data from a community setting. Some primary sources include screening and referral forms, client interviews, medical or healthcare records, the healthcare team including doctors, nurses, occupational therapist, physical therapist, and speech language pathologist just to name a few. Family members and caregivers, community based surveys and focus groups, statistical reports, administrative data, client related outcomes or experience measures, epidemiological studies, and the Malnutrition Screening Tool score.

We have specific Nutrition Assessment terminology that is used in the Nutrition Care Process. Our nutrition assessment data is categorized into the following nine domains. Food and nutrition related history (FH), Anthropometric measures (AD), Biochemical Data, Medical Tests and Procedures (BD), Physical Findings (PD), Client History (CH), Assessment, Monitoring and Evaluation Tools (AT), Etiology Category

(EY), Comparative standards (CS), and Progress Evaluation (EV). The next couple slides will go through each one of these individually.

Let us briefly look at each one of these domains individually. The first domain is Food Nutrition Related History. This domain is not just limited to the intake of food, it also includes medications both prescribed and over the counter. We must also keep in mind to inquire about complementary alternative medication supplements. Additionally, in this category we evaluate knowledge, attitude and beliefs about food as well as access to food as these drive through choices. Physical activity and activity tolerance also influences food choices so we must evaluate these factors. You may also collect other data which is nutrition related client centered measures. Our next category is Anthropometrics, which measures are used to determine body composition, and they include body height, body weight, body frame, body weight change, body mass, growth pattern indices, and body compartment estimates. As dietitians, we must understand and use findings from Biochemical Data, Medical Tests and Procedures. Laboratory data such as electrolytes can help us evaluate hydration status, whereas glucose can help us determine diabetes control. Tests such as gastric emptying studies may help us understand the cause of abdominal pain, whereas understanding the resting metabolic rate will help us determine calorie needs. The last category on this slide is physical findings. The physical exam findings can come from doctors or nurses notes or from a dietitian who has conducted a nutrition focused physical exam.

Client History is our next domain. To fully understand a client, you must understand their personal health, family, and social history. History can come from client and patient records as well as interviews with our patients and clients. Assessment, Monitoring and Evaluation Tools are those that are used to determine health or disease status or risk for disease. Some examples of tools that may be used for assessment include Subjective Global Assessment, Mini Nutritional Assessment Form, the US Household Food Security Module, and the International Disease Diet Standardization Initiative Functional Diet score. Our next category or domain is our Etiology Category. This category is how you are going to use assessment data to communicate the cause or contributing factor to the determine nutritional diagnosis. Some indicators used in this category include beliefs, access, treatment, or knowledge in addition to others. Comparative Standards are those things that we use to determine nutritional needs based on a reference or recommended standard.

Some comparative standards that you might be familiar with would be Mifflin St. Joer, Harris Benedict, or Estimated Energy Requirements for Determining Calorie Needs. Another comparative standard that may be used as a KDOQI guidelines for protein needs in those with renal disease. Last on this slide is Progress Evaluation.

Progress Evaluation of the progress towards the nutritional related goal and determining whether or not that there is a resolution of the nutrition diagnosis. Terms that we're going to see when doing a progress evaluation would be new, active, resolved, or discontinued.

I mentioned critical thinking briefly before. On this slide, we're going to break it down a little bit further. On the left, we see collecting relevant data. It's important that we collect relevant data that's showing that our nutritional problem exists. Examples would be the use of energy intake as evidence for the problem of inadequate energy intake or using percent of food consumed for inadequate oral intake. Next, we see identify need for additional information. We need to determine whether we need to obtain or order data or request additional data to support our nutrition diagnosis. In this case, we see that we might request a Ferritin for improved evaluation of iron status. In the middle we see select tools and procedures. We need to be sure that we're using valid and reliable tools and guidelines that fit the client population that they are recommended for. For example, use a tool such as the Subjective Global assessment, the Mini Nutritional Assessment that I just mentioned to identify malnutrition. Or use guidelines for a nutrition focused physical exam applying tools and procedures. These tools and procedures should not be altered because doing so may affect their ability to detect what we want them to detect. So we should follow the guidelines and instructions for measuring hand grip strength for example. On the far right column, we see Validate data for accurate interpretation of findings, compare them to standards and norms to determine if it makes sense for a reference population. And our example is compare lab data to the established reference range or use growth chart suitable for a client's age.

Quality documentation is extremely important in the Nutrition Care Process, including the Nutrition Assessment. So we have some examples on the slide of poor quality documentation as well as good quality documentation. Looking on our left hand side under #1 we see that our nutrition problem states inadequate energy intake. In our assessment documentation, we read that the comparative standard is stated and that estimated energy needs are 2000 calories per day or 25 calories per kilogram. On the right hand side we see that the problem is also inadequate energy intake, but the estimated energy needs and current intake are not listed to support that that problem actually exists. Our second example is an inadequate fluid intake and our Nutrition Assessment contains a diet recall that summarizes the estimated fluid intake in a 24 hour period of time and it appears to be 75% of needs. Our estimated fluid requirements are noted in our comparative standards. On the other hand, poor documentation would be a diagnostic statement of inadequate fluid intake and a Nutrition Assessment that only contains a diet recall without a summary of fluids in a 24 hour period and the comparative standards only less

energy needs, not fluid needs. Our third example is that when there are abnormal labs related to the nutrition diagnosis, they are listed in the Nutrition Assessment. Poor documentation would be that the Nutrition Assessment includes abnormal labs from several years ago, but they do not contain labs that are current and indicate that the problem would still be relevant.

Let us summarize what we learned about the Nutrition Assessment. The Nutrition Assessment is the first step of the Nutrition Care Process. And because data collected during the Nutrition Assessment is used for all other steps of the Nutrition Care Process, it's important that we give this step the appropriate amount of time and that we thoroughly investigate our client or patient or population. The Nutrition Assessment ultimately leads to the identification of a nutrition problem, also known as the Nutrition Diagnosis. New information or new assessment data may provide a reason for reassessment, which then might lead to a change in nutrition diagnosis or the nutrition intervention.

Thank you for listening to this module on Nutrition Assessment. Please proceed to Module 4, which is Nutrition Diagnosis.