12. RESIDENT ASSESSMENT PROTOCOL: NUTRITIONAL STATUS

I. PROBLEM

Malnutrition is not a response to normal aging; it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. Severe malnutrition is, however, relatively rare, and this RAP focuses on signs and symptoms that suggest that the resident may be at risk of becoming malnourished. For many who are triggered, there will be no obvious, outward signs of malnutrition. Prevention is the goal, and early detection is the key.

Early problem recognition and care planning can help to ensure appropriate and timely nutritional intervention. For many residents, simple adjustments in feeding patterns may be sufficient. For others, compensation or correction for food intake problems may be required.

Within a nutrition program, food intake is best accomplished via oral feedings. Tube (enteral) feeding is normally limited to residents who have a demonstrated inability to orally consume sufficient food to prevent major malnutrition or weight loss. Parenteral feeding is normally limited to life-saving situations where both oral and enteral feeding is contraindicated or inadequate to meet nutrient needs. Oral feeding is clearly preferred. Depending on the nature of the problem, residents can be encourage to use finger foods; to take small bites; to use the tongue to move food in the mouth from side to side; to chew and swallow each bite; to avoid food that causes mouth pain, etc. Therapeutic programs can also be designed to review for the need for adaptive utensils to compensate for problems in sucking, closing lips, or grasping utensils; to help the confused resident maintain a fixed feeding routine, etc.

II. TRIGGERS

Malnutrition problem suggested if one or more of following observed:

- Weight Loss
  [K3a = 1]
- Complains About Taste of Many Foods
  [K4a = checked]
- Leaves 25% or More Food Uneaten at Most Meals
  [K4c = checked]
- Parenteral/IV Feeding[(a)]
  [K5a = checked]
- Mechanically Altered Diet
  [K5c = checked]
- Syringe (Oral Feeding)
  [K5d = checked]
- Therapeutic Diet
  [K5e = checked]

- Pressure Ulcer[b]
  [M2a = 2, 3, or 4]

[a] **Note:** These items also trigger on the Dehydration/Fluid Maintenance RAP.
[b] **Note:** These items also trigger on the Pressure Ulcer RAP.

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO CONSUME FOOD

Reduced Ability to Feed Self

Reduced ability to feed self can be due to arthritis, contractures, partial or total loss of voluntary arm movement, hemiplegia or quadriplegia, vision problems, inability to perform activities of daily living without significant assistance, and coma.

Chewing Problems

Residents with oral abscesses, ill-fitting dentures, teeth that are broken, loose, carious or missing, or those on mechanically altered diets frequently cannot eat enough food to meet their calorie and other nutrient needs. Significant weight loss can, in turn, result in poorly fitting dentures and infections that can lead to more weight loss.

Losses from Diarrhea or an Ostomy

Swallowing Problems

Swallowing problems arise in several contexts: the long-term result of chemotherapy, radiation therapy, or surgery for malignancy (including head and neck cancer); fear of swallowing because of COPD/emphysema/asthma; stroke; hemiplegia or quadriplegia; Alzheimer's disease or other dementia; and ALS.

Possible Medical Causes

Numerous conditions and diseases can result in increased nutrient requirements (calories, protein, vitamins, minerals, water, and fiber) for residents. Among these are cancer and cancer therapies, Parkinson's disease with tremors, septicemia, pneumonia, gastrointestinal influenza, fever, vomiting, diarrhea and other forms of malabsorption including excessive nutrient loss from ostomy, burns, pressure ulcers, COPD/ emphysema/asthma, Alzheimer's disease with concomitant pacing or wandering, and hyperthyroidism.

Malignancy and Nutritional Consequences of Chemotherapy, Radiation Therapy/Surgery - For the resident undergoing therapy aimed at remission or cure, aggressive nutritional support is necessary to achieve the goal; for the resident with incurable malignancy who is undergoing palliative therapy or is not responding to curative therapy, aggressive nutritional support is often medically inappropriate.

- Have the wishes of the resident and family concerning aggressive nutritional support been ascertained?

Anemia (nutritional deficiency, not malnutrition) - A hematocrit of less than 41% is predictive of increased morbidity and mortality for residents.

- Are shortness of breath, weakness, paleness of mucous membranes and nailbeds, and/or clubbing of nails present?

Chronic COPD - Increases calorie needs and can be complicated by an elevated fear of choking when eating or drinking.

Shortness of Breath (frequently seen with congestive heart failure, hypertension, edema, and COPD/emphysema/asthma) - This is another condition that can cause a fear of eating and drinking, with a consequent reduction in food intake.

Constipation/Intestinal Obstruction/Pain - Can inhibit appetite.

Drug-Induced Anorexia - Often causes decreased or altered ability to taste and smell foods.

Delirium

PROBLEMS TO BE REVIEWED FOR POSSIBLE RELATIONSHIP TO NUTRITIONAL STATUS PROBLEM (Causal link)

Mental Problems

Mental retardation, Alzheimer's or other dementia, depression, paranoid fears that food is poisoned, and mental retardation can all lead to anorexia, resulting in significant amounts of uneaten food and subsequent weight loss.

Behavior Patterns and Problems

Residents who are fearful, who pace or wander, withdraw from activities, cannot communicate, or refuse to communicate, often refuse to eat or will eat only a limited variety and amount of foods. Left untreated, behavior problems that result in refusal to eat can cause significant weight loss and subsequent malnutrition.

- Does resident use food to gain staff attention?
- Is resident unable to undertand the importance of eating?

Inability to Communicate

For most residents, enjoying food and mealtimes crucially affects quality of life. Inability to make food and mealtime preferences known can result in a resident eating poorly, losing weight, and being unhappy. Malnutrition due to poor communication usually indicates substandard care. Early correction of communication problems, where possible, can prevent malnutrition.

- Does the area in which meals are served lend itself to socialization among residents? Is it a place where social communication can easily take place?
- Has there been a failure to provide adequate staff and/or adequate time in feeding or assisting residents to eat?
- Has there been a failure to recognize the need and supply adaptive feeding equipment for residents who can be helped to self-feed with such assistance?
- Is the resident capable of telling staff that he/she has a problem with the food being served- e.g., finds it to be unappetizing or unattractively presented?

Amputation

Weight loss may be due to an amputation.

12. NUTRITIONAL STATUS RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Malnutrition problem suggested if one or more of following observed:

- Weight Loss
  [K3a = 1]
- Complains About Taste of Many Foods
  [K4a = checked]
- Leaves 25% or More Food Uneaten at Most Meals
  [K4c = checked]
- Parenteral/IV Feeding[(a)]
  [K5a = checked]
- Mechanically Altered Diet
  [K5c = checked]
- Syringe (Oral Feeding)
  [K5d = checked]
- Therapeutic Diet
  [K5e = checked]
- Pressure Ulcer[(b)]
  [M2a = 2, 3, or 4]

GUIDELINES

Factors that impede ability to consume foods:

- Reduced Ability to Feed Self **[G1h]**
- Ostomy Losses **[H3i]**
- Chewing Problems **[K1a]**
- Swallowing Problems **[K1b]**
- **Possible Medical Causes.** Diarrhea **[H2c]**, Anemia **[I1oo]**, Cancer **[I1pp]**, Pneumonia **[I2e]**, Fever **[J1h]**, Shortness of Breath **[J1l]**, Chemotherapy **[P1a]**, and Nutrient/Medication Inter-actions (e.g., Antipsychotics **[O4a]**, Cardiac Drugs, Diuretics **[O4e]**, Laxatives, Antacids) **[from record]**

Problems to be reviewed for possible relationship to nutritional status problem:

- **Mental Problems.** Mental Retard-ation **[AB10]**, Fear that Food is **P**oisoned **[from record; E1]**, Alzheimer's Disease **[I1q]**, Other Dementia **[I1u]**, Anxiety Disorders **[I1dd]**, Depression **[I1ee]**
- **Behavior Problems.** Pacing **[E1n]**, Withdrawal From Activites of Interest **[E1o]**, Wandering **[E4a]**, Throwing Food **[E4d]**, Slowness in Self-Feeding **[G8c]**, Leaves 25% or More Food Uneaten **[K4c]**
- **Inability to Communicate.** Comatose **[B1]**, Unable to Make Food and Mealtime Preferences Known **[C3g]**, Difficulty Making Self Understood **[C4]**, Difficulty Understanding Others **[C6]**, Aphasia **[I1r]**
- **Functional Problems.** Loss of Upper Extremity Use **[G4a,b,c]**, Amputation **[I1n]**

(a) **Note:** These items also trigger on the Dehydration/Fluid Maintenance RAP.

(b) **Note:** These items also trigger on the Pressure Ulcer RAP.

[This page intentionally left blank]