Clinical Nutrition Program Policies:

1. All patients admitted into the hospital will undergo a nutrition screening process.
2. All patients identified to be "nutritionally at risk" by the nutrition screening process will undergo a formal nutritional assessment to be performed by the clinical nutrition team.
3. All patients referred by the attending physician to the clinical nutrition team for nutrition management or scored by the nutritional assessment process as "severe malnutrition" or "nutritionally high risk" will be given a nutritional care plan by the clinical nutrition team.
4. The clinical nutrition team will perform the following nutrition care management processes:
    a. Implementation of the nutrition care process from nutrient requirement determination, solution formulation, decision/implementation on all aspects of access, and nutrient delivery (oral, enteral, parenteral nutrition, and combinations).
    b. Monitoring of the nutrient delivery process from calorie counting, weight changes, fluid balance, laboratory variables, and others.
    c. Regular reassessment of the nutrition care delivery process (i.e. once every three days or once a week)
5. All aspects of the nutrition care plan implementation and monitoring will be documented for reporting purposes. These are:
    a. Nutrition status profile of patients admitted in the units with a summary of who are underweight and obese (= malnourished for the day)
    b. Whether weight and/or heights were taken regularly or accurately
    c. Intake data of the following patients:
        i. Critical care or ICU patients (% calorie intake or actual intake / computed intake)
        ii. Monitored geriatric and post-surgical patients
        iii. Patients for nutritional build up (i.e. cancer or stroke patients)
        iv. Enteral and/or parenteral nutrition patients
    d. Recommendations for policy changes

Clinical Nutrition Program Procedures: for implementing the clinical nutrition care process

1. Nutrition screening of all patients admitted either in the emergency room or direct from the physicians' clinic will be performed.
    a. This procedure is best done by the nurses since they are the ones who first see and process the admitted patients.
    b. The suggested nutrition screening form is form #1 (see appendix).
    c. The nurses then call the clinical nutrition secretary who notes the patients identified to be "nutritionally at risk".
    d. If there is a hospital computerized database system it would be good to have the required data encoded.
    e. Completion period: within 24 hours of admission.
2. All patients identified to be "nutritionally at risk" will undergo the formal nutritional assessment process.
    a. This procedure is done by the clinical nutrition team, either by the clinical dietitian or the clinical nutrition physician specialist
    b. The nutrition assessment form suggested is form #2.
    c. Completion period: 24 to 48 hours
    d. These are the patients who are identified to be "nutritionally at risk":
        i. Critical care patients
        ii. Geriatric patients who are underweight or with chronic one or more organ failure
        iii. Cancer patients who are unable to have oral intake or very poor oral and/or enteral nutrition intake
        iv. Surgical severely malnourished or post-surgical patients with complications
        v. Transplant patients
3. The nutrition assessment form serves as the document showing the patient's current nutritional status and the options for nutritional management are given to the attending physician which are the following:
    a. Low risk – asks the attending physician if the clinical nutrition team would be involved in the nutrition care of the patient

b. High risk – notifies the attending physician the clinical nutrition team will follow up the patient on a regular basis, but it is still the option of the attending physician to concur with the recommendations (a memo from the medical director is required for this)

4. All high risk patients or the low risk patients formally referred by the attending physician will be given a nutrition care plan, which will be placed on the chart of the patient (this will require a memo by the medical director).
    a. The nutrition care plan will be performed by the clinical nutrition physician or by the clinical dietitian after due consultation with the clinical nutrition physician.
    b. The nutrition care plan form suggested is form #3.
    c. Completion period: 24 to 48 hours.
5. Monitoring will be as follows:
    a. Calorie and protein intake count:
        i. Critical care or ICU patients: First three (3) days after admission, 5^{th}, and 7^{th} day for the first week; twice a week for the succeeding weeks
        ii. Non-critical care: First 24 to 48 hours then twice a week unless specified
    b. Fluid balances – as frequent as the calorie count
    c. Blood sugar – as needed
    d. WBC, TLC (Total Lymphocyte Count), platelet count: three times a week for the first week then as needed on the second week.
    e. Serum albumin – on admission
        i. As nutritional build up indicator – on the third week after the initial test
        ii. As oncotic pressure indicator – as needed
    f. Weight – once a week
    g. Nitrogen balance – once a week
    h. The monitoring form to be used are the following:
        i. Fluid and nutrient balance record (form #4) – may or may not be placed as official record since this is the basis of the final nutrient monitoring summary sheet (form #5).
        ii. Nutrient intake summary form (form #5)
6. Meeting for discussion(s) on the nutrition management of the patient will be done at least three (3) times a week by the clinical nutrition team and the physician or each member of the team

may discuss the progress or plans for the patient with the attending physician after the discussions are finished.

7. Special issues that need to be consulted with the Advisory Team of the Clinical Nutrition Development program of PHILSPEN (or consult the NST Manual):
    a. Criteria for determining severity of weight loss
    b. Criteria for “nutritionally at risk” determination
    c. Total calorie and protein requirement computation guidelines; Non-Protein calories; use of vitamins and trace elements
    d. Modification of requirements in different disease states
    e. Algorithm on enteral and parenteral nutrition decision
    f. Guidelines on oral supplementation
    g. Guidelines on gastric residuals
    h. Guidelines on enteral nutrition (access, formulation, and delivery)
        i. Bolus, intermittent, continuous feeding
        ii. Blenderized versus commercial formulas
    i. Guidelines on parenteral nutrition
        i. All in one versus compounding
        ii. Use of nutraceuticals
    j. Adequacy of intake and choices of nutrient delivery