DT.2.6.2 Body mass index (BMI) for adults.

DT.2.6.3 Eating habits.

DT.2.6.4 Food allergies.

DT.2.6.5 Need for therapeutic diet.

DT.2.6.6 Physical difficulties with eating and drinking and the need for any assisting devices.

DT.2.7 The nutritional screening and assessment findings are documented in the patient's medical record.

Standard Intent:

The most effective way to identify patients with nutritional needs is through screening criteria. Screening generally involves performing a very simple, high-level evaluation of a patient to determine if the patient exhibits a risk that might indicate the need for a more in-depth assessment. For example, the initial nursing assessment form may contain basic criteria for a nutritional screen, such as five or six simple questions with a numerical score relating to recent decline in food intake, weight loss during the past three months, mobility, and the like. The patient's total score would then identify a patient at nutritional risk requiring a more in-depth nutritional assessment. The comprehensive nutritional assessment should follow a policy based on the elements of the substandard DT.2.6.1 through DT.2.6.6.

DT.3 Patients with nutritional disorders have the appropriate nutritional plans that meet their medical needs.

DT.3.1 The dietitian, in collaboration with other clinical staff, develops an appropriate nutritional plan of care for patients with nutritional disorders.

DT.3.2 Patients cultural and food preferences are respected to the extent possible.

DT.3.3 The nutritional plan allows for consideration of:

DT.3.3.1 Enteral tube feeding for malnourished or patients at risk of malnutrition and have inadequate oral intake and a functioning gastrointestinal tract.

DT.3.3.2 Parenteral nutrition for patients with a non-functioning gastrointestinal tract.

DT.3.3.3 Therapeutic diet prescribed for specific health conditions.

DT.3.4 Patients are reassessed for response by the dietitian at regular intervals and adjustments are made accordingly.

DT.3.5 The nutritional plan is documented in the patient's medical record.

Standard Intent:

The diet plan for patients with nutritional disorders should be specific to meet their needs this required collaboration between all involved healthcare providers such as primary physician, primary nurse and the dietitian. The plan should be documented in the patient medical