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 Clinical Rotation-Good Samaritan  
**Sample Nutrition Chart Form Using A-D-I-M-E Format**  
 T.V. -B Unit

**ASSESSMENT:** Summary of subjective and objective data from chart review and patient/caregiver.

Pt's age: 44 y.o. male Dx: COPD exacerbation Medical Problems/PMH: PTSD, depression, past h/o alcohol abuse (quit 4 months ago), asthma, suicide attempt, COPD, DM, Lung CA, DM, arthritis, emphysema, HTN

Ht.	Current Wt	Usual Weight	IBW range /%IBW	BMI
6'4"	181.7# (2/23/12)	205# (per pt.-1 month ago)	202# ±10% 90% IBW	22.1 (WNL)

%Wt loss: 11.3% over 1 month (severe wt. loss)  
 %UBW: 88.6 % (indicates mildly malnourished)

Estimated energy needs: 2475 kcal (30 kcal/kg)	Estimated protein needs: 99g (1.2 g/kg)
Other nutrient needs :	Fluid needs: 2475 mL (30 mL/kg)

Summary of Diet History (24 recall):

Breakfast: 1 small container flavored yogurt
1 medium banana
8 oz coffee- no milk, no sugar
Lunch: Homemade soup (~1 cup),
1 slice white bread with ~1 tbsp butter
8 oz water
Dinner: 4 oz roasted chicken, skinless
½ cup cooked mixed vegetables, 2 tsp butter
½ cup- 1 cup white rice
8 oz water
He reports consuming small portion sizes PTA and not having snacks between meals due to poor appetite. He does not "worry about" his DM in terms of diet because his Dr. told him his Hgb A1c levels were acceptable.

Current Diet Order: 1800 kcal Diabetic  
 Intake approximately 50% at meals and/or N/A from TF and/or N/A from PN  
 May be not applicable (NA) for non-hospitalized persons

Pertinent lab values (2/22/12, ↑ or ↓)

Na: 133↓- may be 2° ↑BG level or Risperdal
K+: 3.9 (WNL)
BUN: 12 (WNL)
Creat: 1.1 (WNL)
Glucose: 112↑-DM, meds (Risperdal, Solumedrol, Protonix, Hydrochlorothiazide)
Hgb: 12.6↓- may be 2° Risperdal
Hct: 37↓- may be 2° Risperdal
MCV: 91.8 (WNL)

Fingersticks (2/23/12)- 129, 120, 110 (times N/A)  
 Hgb A1c- lab value pending

Nutritional Risk Factors (GI, chewing/swallowing difficulties, etc.)

No n/v, diarrhea, constipation, chewing/swallowing problems per pt at this time
↓ appetite and p.o. intake (per pt)

Usual Meds or Dietary supplements

Divalproex-antiepileptic
Acamprostate-alcohol abuse deterrent
Pantoprazole- antigerd, antisecretory
Hctz-antihypertensive, diuretic
Risperdal-antipsychotic
Insulin- antidiabetic

Current Meds/implications/pertinent side effects

Solumedrol-corticosteroid-anti-inflammatory,immunosuppressant-may cause ↑glucose
Protonix-antiulcer,antigerd, antisecretory-may ↓absorption of Fe and B12, ↑glucose
Risperdal-antipsychotic-↑ glucose, ↓Na, ↓Hb and Hct
Trazodone- antidepressant-may ↑ or ↓wt, HTN
Humulin insulin-antidiabetic, hypoglycemic-↓glucose, ↓Hgb A1c
Hydrochlorothiazide-anti hypertensive, diuretic- may need ↓Na in diet, may cause anorexia, ↑ glucose

Food allergies: NKFA

Food intolerances: does not like milk

Stage of Change: He appears to be in action stage for ↑ p.o. intake- accepted suggestions for oral supplement, snacks, written materials on ↑protein/calorie intake. He verbalizes not wanting to lose more weight.

Other Comments: He is not open to discussing his Diabetic Diet order at this time.

**NUTRITION DIAGNOSIS(ES):**

Problem                      Etiology (*related to*)                      Signs and Symptoms (*as evidenced by*)

P-E-S Statements:

Increased nutrient needs (calories, protein) (NI-5.1) related to COPD exacerbation as evidenced by unintentional wt loss, current diet Rx not meeting estimated needs.


**INTERVENTIONS (Food/and/or Nutrient Delivery; Nutrition Education; Nutrition Counseling; Coordination of Nutrition Care)**

GOALS	PLANS
1. Pt will receive and tolerate appropriate therapeutic Diet within 48 hours.	- Suggest diet change to 2400 kcal Diabetic, NAS
2. Pt will meet at least 50-75% of estimated nutrient needs via P.O. intake of meals and supplement within 5-7 days.	-Suggest 8 oz vanilla glucerna 1x/day -Suggest diet change to 2400 kcal provide adequate calories
	-Updated preferences for meals, serve yogurt

	instead of milk at meals, and provide HS snack of pt choice
	-Provided education (verbal and written materials) on increasing intake of calories/protein, high kcal/high protein snacks -Monitor p.o. intake of meals, snack, supplement
3.Pt will maintain within 1-2 # x 7 days.	-Monitor wt weekly

**MONITORING: ✓ all that apply**

- ✓Weight      ✓food intake at meals      ✓supplement intake
- ✓Labs (specify) (CBC, Hgb A1c when available, fingersticks)

Other- Follow up for appropriate time to educate on NAS diet (pending MD approves order)

**EVALUATION: (only for follow-up)**

Previous Problems -- Clinical Concerns:  
Comment on Progress \_\_\_\_\_

Previous Problems -- Behavioral-Environmental Concerns:  
Comment on Progress \_\_\_\_\_

Previous Intake compared with Current Intake: \_\_\_\_\_  
Comment on Progress \_\_\_\_\_

Previous Educational Needs and Sessions Provided: \_\_\_\_\_  
Comment on Progress \_\_\_\_\_

Other Evaluations and Plans or Recommendations:

Date: 2/24/12 Dietitian Name: Michelle Hyman-Dietetic Intern

**Evidence Analysis Library: Factors affecting energy needs in patients with COPD who are ambulatory/stable or during an exacerbation:**

The EAL reviewed eighteen studies regarding energy needs in people diagnosed with COPD. The EAL concluded that total daily energy needs of people with COPD are highly variable because of differences in resting energy expenditure and levels of physical activity. In both people with stable COPD and those experiencing an exacerbation, the presence of inflammation increases resting energy expenditure. More research is needed to determine the energy needs in patients with COPD and COPD exacerbation is needed (Grade III).

**Effect of nutritional supplementation (grade II):**

Studies have shown that in the inpatient setting, nutritional supplementation for 7 - 12 days resulted in increased energy consumption and weight maintenance. In the outpatient setting, nutritional supplementation also resulted in increased energy consumption, and with weight gain. However, authors of a review published in 2005 of 12 studies concluded that nutritional supplementation for more than two weeks did not have a significant effect on anthropometric measures or exercise capacity in patients with stable COPD. More research is needed on the effect of nutritional supplementation in patients with COPD.

**Recommendation from EAL:** For inpatients with COPD that have either a low BMI (under 20kg/m<sup>2</sup>), unintentional weight loss, decreased p.o. intake or are at nutritional risk, Registered Dietitians should initiate provision of oral supplements.