Nutritional Outcomes in the Community Setting

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Community Dietitian

Southern Health and Social Care Trust
Quality Care - for you, with you
Content

• Outcomes….What, Why & How!
• Experience of Outcomes journey
• Examples
• Working examples and practice
• Discussion
What is the Outcomes process?

• Implementation of the BDA Model and Process for Nutrition and Dietetic Practice
• Process to ensure consistent quality of practice – evidence based
• Provides evidence of achievement in a range of outcomes, thereby indicating benefit & effectiveness of the dietetic intervention
• Ensures consistent record keeping – thereby improving patient care
Why measure Outcomes?

• Provide evidence of professional clinical decision making
• Promote the profession
• Provide evidence to support Dietetics role within team/directorate
• Client centred and focused
• Continuity of care
• Standardised practice
• Embrace the international agenda
How to measure Outcomes?

1. Nutritional Assessment
2. Nutritional Diagnosis
3. Measurable Outcomes
Journey Experience - Challenges

• Suspend Judgement
• New way of thinking...critical analysis!
  – Finding patterns and relationships among the data and possible causes
  – Making inferences
  – Prioritising the relative importance of problems
• Time consuming initially
  – Ruling in/Ruling out specific diagnoses
  – Establishing the ND
  – Card Structure
  – Altering outcome measures
Journey Experience - Positives

• Standardises practice
• Record cards are structured and succinct
• Focuses on dietetic intervention and targets
• Provides measurable targets
• Patient centred
• Aids review process
• Provides evidence for change of plan/discharge
Staff comments

Initially stressful - new way of thinking

Cuts down writing in care plan

Keeps you more focused with use of clinical judgement

Very useful for review as clear where the focus is

Initially takes more time but gets easier!
Writing Nutritional Diagnosis: PESS

- **Problem (What?)**
  - Identify the *nutritional* problem
  - ‘Risk of’ ‘Increased’ ‘Decreased’ ‘Impaired’ ‘Ineffective’

- **Etiology (Why?)**
  - Identify *primary* cause of the *nutritional* problem
  - ‘Related To’

- **Signs & Symptoms (How do I know?)**
  - State the *nutritional* Signs and Symptoms
  - ‘As Evidenced By’
Nutritional Diagnosis: Example

• 78yr old woman: nursing home resident

• Medical Diagnosis: Dementia

• Nutritional Ax: Weight 50kg, wt loss 5kg x 3/12, BMI 17, behavioural issues at meal times, refusing & pushing food away, pureed diet & stage I thickened fluids. Energy & protein intake 850kcals and 30g protein, fluids 600mls/d
### Nutritional Diagnosis: Example

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Nutritional Diagnosis</th>
<th>Desired Outcomes</th>
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</thead>
<tbody>
<tr>
<td>• Weight loss</td>
<td>Unintended weight loss RT inadequate energy &amp; fluid intake AEB food refusal, 10% weight loss x 3/12, BMI 17kg/m² and meeting 56% of estimated energy and 60% protein needs</td>
<td>Halt weight loss – maintenance at 50kg</td>
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<tr>
<td>• BMI 17kg/m²</td>
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<td>Increase fluid intake - 2 extra gls/d</td>
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<td>• 10% weight loss</td>
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<td>c/o ONS</td>
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<td>• Meeting 56% estimated energy and 60% protein needs</td>
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Dietetic Outcomes

• SMART
  – Weight maintenance / Halt weight loss / % gain
  – BMI range
  – Hgb increase to normal range

• Keep to 2 -3 outcomes

• Change as required

• Record how these are to be achieved ...i.e. Food fortification/ONS
<table>
<thead>
<tr>
<th>Outcome Domain</th>
<th>Outcome measure</th>
<th>Start Measure Date: (1st assessment)</th>
<th>State overall outcome/ end target</th>
<th>Review Date: Value (A/PA/NA)</th>
<th>Variance</th>
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<th>Review Date: Value (A/PA/NA)</th>
<th>Variance</th>
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<tbody>
<tr>
<td>A. PATIENT FOCUSED Specific patient focussed aim</td>
<td>1. Whatever the individual has identified as of importance to them/negotiated plan of care</td>
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<td>B. PSYCHOLOGICAL Increase importance, motivation, confidence, self esteem and/or knowledge/understanding</td>
<td>1. Improved patient/carer importance 2. Improved patient/carer motivation 3. Improved patient/carer confidence 4. Improved self esteem 5. Reported increased knowledge/understanding of condition (scale 1 – 10)</td>
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<td>D. BEHAVIOUR CHANGE</td>
<td>1. Intake changed to meet estimated requirements (dietary Ax for calories and protein including ONS if applicable) 2. Improved eating pattern / compliance with meal plan 3. Improved eating awareness 4. Binge eating behaviour improved 5. Restrictive eating behaviour improved 6. Volume of ONS consumed</td>
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<td>Meet fluid requirements</td>
<td>7. Fluid intake, measured or reported (mls, cups etc.)</td>
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<td>Improved physical activity and/or function</td>
<td>8. Patient-reported changes in physical activity and/or function</td>
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<td>E. SYMPTOMS</td>
<td>Improve bowel function/symptoms</td>
<td>1. Improved IBS Symptom Assessment</td>
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<td>Improve symptoms nausea/vomiting</td>
<td>2. Bristol Stool Scale</td>
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<td>3. Improvement in pain</td>
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<td>4. Improvement in nausea and/or vomiting</td>
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<td>5. Decrease fistula/stoma output</td>
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<td>6. Other: specify:</td>
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<td>Reduce allergy symptoms</td>
<td>7. Improved allergy symptoms (e.g. eczema)</td>
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<td>F. BIOCHEMICAL</td>
<td>Improve biochemical status</td>
<td>1. Improved urea &amp; electrolytes</td>
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<td>2. Improved renal profile</td>
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<td>3. Improved inflammatory markers</td>
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<td>4. Improved re-feeding bloods</td>
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<td>5. Improved full blood count</td>
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<td>6. Improved liver functions test's</td>
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<td>7. Improved micronutrients</td>
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<td>8. Improved lipid profile</td>
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<td>Improve blood glucose levels/control</td>
<td>9. Reduced hypoglycaemia episode</td>
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<td>10. Reduced hyperglycaemia episodes</td>
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<td>11. Improved HbA1c</td>
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<td>12. Improved BMs</td>
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A = Achieved, PA = Partially Achieved, NA = Not Achieved
Review

• Use outcome targets as a baseline record
• Identify any further issues
• Re-evaluate Nutritional Diagnosis
• Clinical Effectiveness - Achievement of outcomes
  • A – Achieved, PA – Partially Achieved, NA – Not Achieved
• Highlight variances if required, i.e. Non-compliance, unrealistic target
• Alter nutritional care plan and outcome measures subsequently
Variance

Record any variances to the outcome:

1. Unrealistic goals
2. Non compliant
3. DNA
4. RIP
5. Unsafe e.g. patient aggressive
6. Unable to set aims
7. Change of nutritional diagnosis
8. Other

- Remember: Variances apply only if the dietetic outcome is changed

- **Apply Variance** if the initial agreed target weight of 53kg changes to 50kg due to unrealistic goal

- **Don’t Apply Variance** if the agreed target weight remains 53kg, but the client has lost weight due to an acute episode of illness
<table>
<thead>
<tr>
<th>Setting: Clinic: C</th>
<th>Medical Diagnosis</th>
<th>Nutritional Diagnosis</th>
<th>Outcome measures Domain Number e.g. A1/B3</th>
<th>Start date</th>
<th>Date of review/s</th>
<th>Date of next planned r/v D/C RIP</th>
<th>Notes</th>
<th>Audit Date</th>
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<td>Other: O</td>
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Case Study - A

• Mrs X had a CVA 2yrs ago, bedbound but stable. Cared for at home. No oral intake. PEG in-situ. Carers report weight gain 6kg x 8/12, 79kg, BMI 31kg/m²

• PEG feed protocol in place from hospital. Has not been adjusted since then but carers give extra sip feeds via PEG. Not following the feed regime.
Answer: A

- **Nutritional Diagnosis** – Weight gain RT excess nutritional requirements provided AEB additional food and fluids being given by carers despite feed regime in place.

- **Overall Outcome**: Achieve healthy range BMI

- **Measurable Outcomes**:
  - A1: Return to UBW
  - B5: Pt energy and protein requirements discussed and feed regime explained
  - C1: Aim for healthy range BMI or return to baseline wt
84yr old female
Med Hx: Anaemic Hgb 99, Ferritin 10.3, constipation, cognitive impairment
Weight hx: 60kg on referral, 59.3kg at assessment, BMI 24kg/m²
Medication: Ferrous fumarate, omeprazole, amlodipine, amitriptyline
Social Hx: Lives alone, uses microwave and toaster for all meals, does not use gas stove due to accident risk, neighbour brings her shopping
DHx: 1 main meal/d - ready meal, snacks on rice krispies, bread, soup. No fruit, little veg. 700kcals and 24g protein, 800mls fluid/d
Requirements: 1640kcals/d, 59-71g protein/d, 1.8L fluid/d
Pt reports: reduced po intake due to nausea, decreased cooking ability due to unsteadiness on feet and limited knowledge re use of microwave, limited shopping choices, visits one shop only x 1/7. Constipation and nausea her main issues
Answer - B

• **Nutritional Diagnosis:** – Poor nutritional and hydration status RT cognitive impairment, decreased functional domestic ability AEB pt meeting 43% estimated energy, 41% protein & 44% fluid needs, anaemia and constipation.

• **Overall outcome:** Improve dietary variety, 3 regular meals/d

• **Measurable outcomes:**
  – A1: Resolve nausea and constipation
  – B5: Increase fibre, iron knowledge and microwave use
  – D2: 3 meals/d
  – D7: 4-5 gls /d
Case Study - C

- 79yr old lady staff feel pt is deteriorating slowly
- Med Hx: Dementia, CCF, DVT, CKD stage III, Sacral Sore grade III, dysphagia
- Social Hx: nursing home resident
- Weight hx: 68.7kg BMI 27kg/m² (July 2012), 45.8kg BMI 18kg/m² (May 2014)
- DHx: 1200kcals, 48g protein, managing full pureed meals & snacks, ONS 600kcals 18g protein......appetite excellent
- EER: Protein: 46 -55g/d
Answer - C

• Nutritional Diagnosis: Risk of poor nutritional status RT general deterioration & dysphagia AEB BMI 18kg/m², grade III sacral sore despite meeting 100% estimated energy and protein needs with ONS.

• Overall Outcome: Weight maintenance

• Measurable Outcomes:
  – C1: Weight maintenance
  – C8: Sacral sore improvement
  – D1: Maintain current intake to meet requirements