The Integrated Nutrition Pathway for Acute Care (INPAC) Audit

The INPAC is an evidence-based algorithm for the prevention, detection, treatment and monitoring of malnutrition in acute care medical/surgical patients. The algorithm is based on consensus from leading Canadian experts, clinicians and other stakeholders (Keller et al, 2015).

The ***INPAC Audit*** is a tool to help healthcare teams track routine nutrition care activities on one unit. Auditing practice will help to determine progress with the implementation of INPAC activities in a unit/hospital (e.g. screening at admission). These audits represent the status of activities as of the audit date/time and may not capture all activities (i.e. some activities may be completed later in the day).

How to complete the audit:

- Any staff member can be trained to complete the audit
- Data can be collected from any of the following sources of information, typically available on the patient health record:
    - *Order sheets*
    - *Assessment forms (physician, nurse, dietitian, other allied health)*
    - *Diagnostic records/reports*
    - *Monitoring records*
    - *Progress notes*
    - *Department specific documentation*

Note: Use the same data sources for each audit. It is also advisable to use the same staff member or a small group of trained staff members to complete audits, to ensure that variability over time is due to improvement and change management practices. Data should only be inputted from written documentation, and should not include verbal sources (i.e. if a staff member verbally mentioned a task was completed, but it is not in the notes, this should not be included).

When to complete the audit:

- To assess baseline levels before implementation of a new care activity begins it is recommended to complete 2-4 audits over a relatively short time span (e.g. 2 months).
- It is recommended to complete the audit once per month after implementation of a new activity has started.
- To complete the audit, data is collected from the documentation for every patient on the unit that day, even if they are just admitted or about to be discharged.

Audit Item Clarifications:

Auditor initials: Initials provide an opportunity for auditors to self-identify if any questions arise as a result of the audit.

Codes: Codes can be developed for the unit hospital; these should be unique identifiers e.g. Unit 3A at Hudson Bay Hospital.

A patient identifier: Keeping this identifier as generic will help to keep patient information confidential; for example, the following identifies the unit and bed that the patient occupied during the audit (3A1D)

Date of audit and *audit number:* These will help to keep track of audits and ensure that data are included in the correct month of implementation.

1. **Patient information:**
    a. *Birthdate:* To keep the data anonymous, only collect the year of birth (not day or month). Age can be calculated from year of birth to provide descriptive information on patients. Record sex for this purpose as well.
    b. *Date admitted to unit:* This should be the date admitted to the current unit on which the audit is being completed.
    c. *Transfer:* Transfer information is useful when practices vary by unit, for example, if screening is not completed on all units. Indicate if the patient has been transferred from another unit in the hospital (not other hospitals). Review documentation from the beginning of this hospitalization to determine if INPAC activities were completed.
2. **Diagnoses**: List all medical diagnoses that are being treated/managed as part of the current hospital visit, not from previous admissions.
3. **Screening:** Indicate if screening was completed and the result of risk/no risk. If not completed, attempt to identify and provide the reason (e.g. new to unit, transfer from ICU/CCU and dietitian treatment already initiated etc.)
4. **Subjective global assessment (SGA):** There are three potential options for this question and one must be completed.

    Option 1: SGA was completed; also provide the result of SGA A, B or C.

    Option 2: Referred for SGA, but yet to be completed.

    Option 3: SGA not completed; identify the reason, either because the patient was not at risk or another specific reason.
5. **Comprehensive dietitian nutrition assessment:** There are four options to this question and one must be completed.
    - No assessment required is checked when the patient is not at risk and/or is an SGA A/or B. In some units/hospitals SGA B patients will be routinely provided

advanced care strategies and not automatically undergo a comprehensive dietitian assessment.

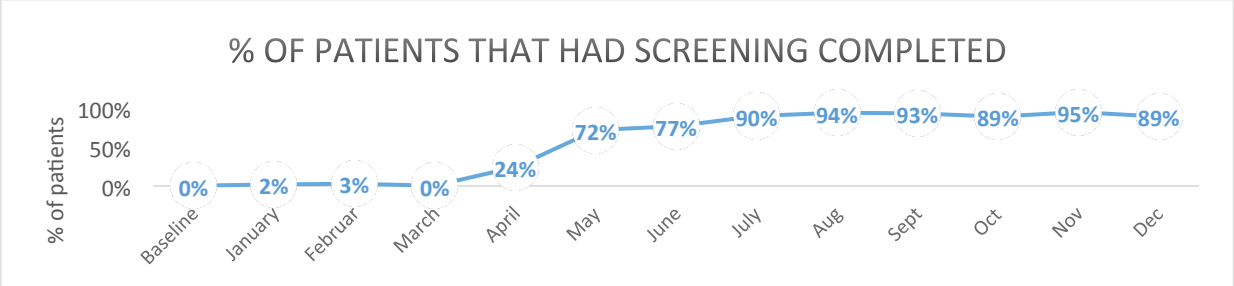
- If option of 'not completed' is selected, this would indicate the assessment should have been completed (i.e., SGA C or in some units/hospitals also SGA B). Provide a reason for non-completion (e.g. palliative).

6. **Nutrition treatment of SGA B or C patients:** Check all treatments provided to patients identified to be SGA B or C. ONS= Oral nutritional supplement. Fill in additional details if "other" is selected.
7. **Food intake monitoring:** This question has several parts, dependent on the prior answer. If 7a = no, skip to question 8. If 7b= no, skip to question 8. If 7c= no, skip to question 8. For 7d, provide any actions taken that were triggered by low food intake. Some actions may have been in place before food intake monitoring was completed; only record new actions triggered by the food intake monitoring.
8. **Body weight (admission):** Indicate *yes* if a body weight measurement was completed at admission (not estimated).
9. **Body weight (monitoring):** Indicate *yes* if a body weight measurement was completed after admission (not estimated).
10. **Discharge:** Nutrition discharge planning can take many forms. What is important to note is if any such planning/education or organizational activities with respect to discharge are noted on the chart and other documentation e.g. discharge planning discussed in rounds and specific to malnutrition, food access etc. To be noted here, this activity has to be specific to nutrition.

Note: This audit is provided in Word format so that additional nutrition care activities pertinent to the unit/hospital can be included as desired.

How to Report Results:

As the audit tool is meant to track progress over time, report results back to the healthcare team so they are aware of the progress. Below is an example of an audit tracking report created using Word/Excel.



INPAC Audit

Auditor Initials: _____

Unit/Hospital: _____

Patient Identifier Room/Bed: _____

Date: _____ Audit #: _____

1. Patient Information

Year of Birth (YYYY): _____

Sex: ☐ Male ☐ Female ☐ Other

Date admitted to unit: (YYYY-MM-DD): _____

Was the patient transferred? ☐Yes ☐No If yes, transferred from where? _____

2. Specific medical diagnoses that are being addressed in this hospitalization

3. Nutrition Screening

☐ Completed; At Risk: ☐Yes ☐No

☐ Not completed: *Reason not completed:* _____

4. Subjective Global Assessment

☐ Completed:
- ☐ A (well nourished)
- ☐ B (mild/moderate malnutrition)
- ☐ C (Severe malnutrition)

☐ Referred, not yet completed

☐ Not Completed; *Specify why:*
- ☐ Not at risk
- ☐ Other: *Specify reason*: _____

5. Comprehensive Dietitian Nutrition Assessment Completed

- ☐ No, not required (not at risk/SGA A and/or B)
- ☐ Yes, required and completed
- ☐ Referred, not yet completed
- ☐ Not completed: *Specify why?* _____

6. Action taken to improve nutrition for SGA B or C patients (check all that apply)

- ☐ No action
- ☐ ONS as medpass (small amount of nutrient dense product)
- ☐ ONS at other times/with meals
- ☐ Nutrient dense diet
- ☐ Liberalized diet
- ☐ Enteral nutrition
- ☐ Parenteral nutrition
- ☐ Other: *Specify*:_____

7. a. Food intake monitoring has occurred ☐ Yes ☐ No skip to 8

b. Food intake is ≤ 50% ☐ Yes ☐ No skip to 8

c. Intake ≤ 50% triggered local action plan ☐ Yes ☐ No skip to 8

d. Action taken to improve nutrition when food intake is ≤ 50% (check all that apply)

- ☐ No new action
- ☐ RD consult
- ☐ ONS between meals/at medication times
- ☐ Nutrient dense diet
- ☐ Liberalized diet
- ☐ Other: *Specify:*_ _____

8. Body weight (measured) was recorded at admission ☐ Yes ☐ No

9. Body weight monitoring post admission has occurred ☐ Yes ☐ No

10. Has a NUTRITION discharge plan/summary, education, and/or recommendation for follow up post discharge been initiated?

☐ Yes ☐ No *If yes, please specify details:* _____