Patient Meal Intake Record

What do we know from the Nutrition Care in Canadian Hospitals study (2010-2013)?

- 45% of patients admitted to Canadian hospitals are malnourished.
- Food intake of 50% or less extends length of hospital stay, even in well-nourished patients.
- 75% of malnourished patients were missed by current dietitian referral processes.

What is the Patient Meal Intake Record?

It is a new form for recording patient meal intake and follow-up over a 7-day period.

Why do we need it?

- To make it easier for staff to monitor and identify trends in patient meal intake.
- To incorporate a process to identify barriers to patient food intake and the necessary follow-up corrective action.
- Integrated Nutrition Pathway for Acute Care (INPAC) that is being implemented on N3W as part of the More-2-Eat research study uses changes in patient food intake to determine nutrition care strategies/practices pertinent to the patient.

What is the process for recording patient meal intake?

- At admission and weekly thereafter, a Patient Meal Intake Record is posted for all patients onto their room door.
- When picking up the patient tray after mealtime, the health care aide (or other unit staff):
  ✓ Will assess the tray for percentage (%) of food consumed (can make reference to the “Assessment of Patient Food Intake” poster in the room) AND write the % on the Patient Meal Intake Record.
  ✓ Will ask the patient two questions if meal intake is 50% or less:  
    *Is your appetite less than usual?*  *AND Do you have mealtime challenges?*
    If patient answers “Yes” to either question, staff will inquire further with patient/family to determine cause(s), write corresponding legend number (or other comment) on the Record and initial.
  ✓ Will take necessary corrective action, if applicable, to improve/solve the problem, write the corresponding legend number (or other comment) on the Record and initial.
Are there any tips that will help me complete the patient meal intake record?

- When selecting a standard meal intake % value (ie 0, 25, 50, 75, 100%), choose the value closest to the assessed intake. For example, if patient only took a few bites, record “0”. If patient only left a few bites on the meal tray, record “100”. You do not need to record the percentage symbol.
- If the patient is NPO for the meal, write “NPO” in the Intake % column and not “0”.
- When assessing % of meal consumed, include all food and fluids on meal tray (except oral nutritional supplements).
- Give less emphasis to the intake of tea, coffee and soup, as these foods generally have the least nutritional value.
- Intake of oral nutritional supplements (ONS) such as Ensure® or Boost® should not be included in the meal intake %. If a supplement is consumed at meal time, report it by writing, for example, “ONS – 50”. Use the same standard %’s as for meals.
- If the patient does not know what “mealtime challenges” would include, you can provide some examples (as listed in the legend on the Record) to create discussion.
- A Clinical Dietitian referral should be sent if patient intake is: 50% or less, for at least 2 meals per day, for 3 consecutive days.
- If patient continues to have meal intake that is 50% or less and the dietitian has already been consulted and completed an assessment, do not send a new referral. Instead, under “Action Taken” column, write “RD following”.
- Refer to the specific “Guidelines for Use” on page 2 of the Record.

When will the new form be available for use?

N3W, participating in the More-2-Eat research study, will be trialing the new form for one month starting October 17, 2016.

Can I provide feedback on the new form/process? What if I have questions?

Yes. After the first 2 weeks, there will be a review completed and staff input will be requested. If you have any questions during the trial, contact a dietitian (Chelsa Marcell, Stephanie Barnes, or Donna Butterworth), the N3W clinical manager or Family Medicine program educator.