
 <p>وزارة الصحة Ministry of Health</p>	<p>المملكة العربية السعودية وزارة الصحة الادارة العامة للطب المنزلي</p>	 <p>الطب المنزلي Home Medical Care</p>
<p><b>Title : Initial Nutritional Assessment</b></p>	<p><b>Policy NO.: HMC-PAA-PPG-006E(3)</b></p>	<p><b>Issue Date : 11/05/2016</b></p>
<p><b>Applied To: All HMC Staff</b></p>	<p><b>Page: ١ Of 3</b></p>	<p><b>Due: 11/05/2019</b></p>

### 1. **Purpose:**



- 1.1.To ensure that the nutritional requirements for patients at home are being monitored and managed.
- 1.2.To ensure that high risk patients nutritional status are being reviewed by dietician at regular intervals.
- 1.3.To provide a guideline for assessing patient's nutritional status and identified as nutritional risk who needs to be evaluated by a registered Dietician.

### 2. **Definition:**

2.1.N/A

### 3. **Policy:**

- 3.1.All patient nutritional status should be assessed upon enrollment to Home Medical Care Unit using nutritional screening tool which is documented in the patient file on admission .
- 3.2.Staff should document nutritional assessment on assessment form and care plan during home visits.
- 3.3.The nutritional assessment should include the following information as part of baseline data:
  - 3.3.1. Diet/Appetite .
  - 3.3.2. Height/weight(estimated).
  - 3.3.3. Digestive disorders.
  - 3.3.4. Dysphagia(swallowing difficulties).
- 3.4.Patient should be assessed for any change of Nutritional status.
- 3.5.High risk patient should be referred to Dietician for counseling and follow up with HMC physician.
- 3.6.The HMC team should identify patient and risk of malnutrition during home visits and referred to HMC Dietician .
- 3.7.Patient who are concenter at high risk of malnutrition should be given priority for dietician home visit.
- 3.8.Result of Nutritional assessment should be discussed with the HMC physician.

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3.9.A plan of care, discussion and interventions should be documented in the patient file.

#### 4. Procedure:

4.1.Nutritional screening will done during initial assessment visit using nutritional screening form.

4.2.When patient discover as at high risk for malnutrition full Nutritional Assessment will done.

4.3.High risk patient should be assessed regularly every 3 months for malnutrition.

4.4.High risk patient for altered nutritional status or at risk of malnutrition include but not limited to:

4.4.1. Patient who are non-compliance to special dietary advice e.g. Diabetic diet.

4.4.2. Bedridden patients with chronic wound(s).

4.4.3. Palliative patients who are not tolerate oral diet.

4.4.4. Patient with morbid obesity.

4.4.5. Any patient with morbid obesity.

4.4.6. Cancer patient.

4.4.7. HIV/AIDS.

4.4.8. Anorexia.

4.4.9. Dehydration.

4.4.10. Gastrointestinal problems.

4.4.11. Non healed wound.

4.4.12. Chronic cardiac and Pulmonary disorders.

4.5.Assessment of factors that affect the nutritional status of the patient which include:

4.5.1. Nausea/Vomiting.

4.5.2. Diarrhea/constipation.



4.5.3. Psychological problems.

4.5.4. Oral hygiene/Dental caries.

4.5.5. Environmental factors.

4.5.6. Hydration status.

4.6.Continuous health education for patient/family and caregiver about nutritional status of the patient and dietary regimen.

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**5. Responsibility:**

5.1.Clinician.

5.2.Dietician.

**6. Forms:**

6.1.Nutritional Screening

6.2.Nutritional Assessment

**7. Reference:**

7.1.Policies and procedures guidelines of Home Medical Care Center, Home Medical Care Administration, Medina Munwara Region, 2016.

7.2.Policies and procedures guidelines of Home Health Care Unit, Family and Community Medicine Department at Riyadh Military Hospitals,2014

7.3.Joint Commission International Accreditation Standards for Home Care, 2012

7.4.MOH Home Medical Care Standard, 2015

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