nutritionDay WORLDWIDE

SHEET 1

Date[1] _ _ / _ _ / _ _ _ _

Center Code[2] ☐☐☐☐

Unit Code[3] ☐☐☐☐

Actual number of beds that are staffed[13]	☐☐ beds
Maximum number of beds in the unit[14]	☐☐ beds
Main patient group admitted (please use code below)[15]:	☐☐

A	internal medicine/general	K	cardiothoracic surgery
B	internal medicine/gastroenterology & hepatology	L	orthopedic surgery
C	internal medicine/ oncology (incl. radiotherapy)	M	trauma
D	internal medicine/ cardiology	N	neurosurgery
E	internal medicine/ infectious diseases	O	gynaecology/obstetrics
F	internal medicine/ geriatrics	P	long-term-care
G	neurology	Q	others (please describe)_____
H	psychiatry	R	internal medicine/ nephrology
I	Ear Nose Throat (ENT)	S	pediatrics
J	general surgery		

People working on your unit (excluding persons cleaning only)[16]:

	number (morning shift) in training	number (morning shift) fully trained
Physicians	☐	☐
Consultants	■	☐
Registrars	☐	■
Nurse	☐	☐
Nursing Aide	☐	☐
Dietitian	☐	☐
Dietetic assistant	☐	☐
Physiotherapist	☐	☐
others (please describe)		

morning shift

Is there a person on your unit dedicated to nutritional care?[9]	◯ YES	◯ NO
Is there a clinical nutrition team in your hospital?[9]	◯ YES	◯ NO
Do you routinely use written procedures for nutritional care?[9]	◯ YES	◯ NO
Which one[9] ...		
national guidelines	◯ YES	◯ NO
local standards	◯ YES	◯ NO
individual patient nutritional care plans	◯ YES	◯ NO
other	◯ YES	◯ NO
Do you screen your patients at admission for risk of malnutrition?[9]	◯ YES	◯ NO
Which screening tool do you use?[9]		
Nutritional Risk Screening (NRS) 2002	◯ YES	◯ NO
Malnutrition Universal Screening Tool (MUST)	◯ YES	◯ NO
national tool	◯ YES	◯ NO
local tool	◯ YES	◯ NO
experience	◯ YES	◯ NO
other	◯ YES	◯ NO

If the patient is at risk for malnutrition or malnourished - what do you do? (Tick more than one if necessary)[10]	**risk**	**malnourished**
develop the individual nutrition care plan	◯	◯
call a dietician	◯	◯
call the nutrition support team	◯	◯
call a gastroenterologist	◯	◯
others	◯	◯

When do you weigh your patients? (Tick more than one if necessary)[10]

◯ at admission ◯ every week ◯ occasionally ◯ when requested ◯ never

COMMENTS:[17]

Each exponent corresponds to the numbers at the explanations.

Sheet 2 Sheet N°[18] ☐☐ Center Code[2] ☐☐☐☐ Unit code[3] ☐☐☐☐ **Date**[1] _ _ / _ _ / _ _ _ _

"Unit all patients"

nutritionDay WORLDWIDE

initials	N°	f/m	P		YYYY	kg	cm	N°	days	Y/N	Y/N	days	1,2,3,...	lines & tubes	AO	C
Patient ☐☐ ☐☐ (4 initials)[4]	Patient's Number[5]	Gender[6]	Patient's Code 1 + 2[19]		Year of birth (YYYY)[7]	WEIGHT[20]	HEIGHT[20]	How many different drugs orally?[21]	Days since hospital admission[22]	ICU stay?[23]	Patient is waiting for operation?[9]	Time since operation[24]	Nutrition therapeutic code[25]	Lines & tubes[26]	Affected Organs (all)[26]	Comorbidity[26]

PATIENT'S CODE 1

H = needs help completing the sheets

NA = not applicable

C = did not give consent

PATIENT'S CODE 2

t = terminally ill

n = **not** terminally ill

NUTRITION THERAPEUTIC CODE

1 = enteral Nutrition

2 = parenteral Nutrition

3 = enteral + parenteral Nutrition

4 = special diet

5 = protein/energy supplement

6 = hospital food

7 = others

LINES & TUBES

CV = central venous

NG = nasogastric

NJ = nasojejunal

ES = enterostoma

PEG = percutaneous endoscopy / surgical gastrostomy

PEJ = percutaneous endoscopy / surgical jejunostomy

PPN = peripheral parenteral nutrition

O = others

AFFECTED ORGANS

1 = brain, nerves

2 = eye, ear

3 = nose, throat

4 = heart, circulation

5 = lung

6 = liver

7 = gastrointestinal tract

8 = kidney, urinary tract, female genital tract

9 = endocrine system

10 = skeleton, bone, muscle

11 = blood/bone marrow

12 = skin

13 = ischaemia

14 = cancer *)

15 = infection

16 = pregnancy

17 = others

*) please fill in onco sheets 1-3

COMORBIDITY

1 = Diabetes I/II

2 = Stroke

3 = COPD

4 = myocardial infarction

5 = cardiac insufficiency

6 = others

Each exponent corresponds to the numbers at the explanations.

nutritionDay

Patient Sheet 3a

Date[1] _ _ / _ _ / _ _ _ _

Patient's N°.[5] ☐☐

Unit Code[3] ☐☐☐☐

Dear patient,
we would like to ask you to fill this questionnaire today to improve our nutritional care in the unit.
We would like to know what you eat, how you feel and how active you are.

Please tick ⊗ or fill in m

THANK YOU FOR HELPING!

Patient's-Initials[4] - First name ■■ Last name ■■ Year of birth[7] ☐☐☐☐

Gender (f/m)[6] ☐ **Your weight 5 years ago**[27] ☐☐☐ kg **O** I do not know

---

Have you lost weight unintentionally within the last three months?[11]

O YES **O** NO **O** NO, I've gained weight **O** I do not know

If YES, how many kilos did your weight decrease?[11]

O 1-2 kg **O** 4-5 kg **O** 7-8 kg **O** 10-11 kg **O** 13-14 kg **O** I am not sure

O 2-3 kg **O** 5-6 kg **O** 8-9 kg **O** 11-12 kg **O** 14-15 kg

O 3-4 kg **O** 6-7 kg **O** 9-10 kg **O** 12-13 kg **O** more than 15 kg

---

How well have you eaten during the last week?[12]

O normal

O a bit less than normal

O less than half of normal

O less than a quarter to nearly nothing

I ate less because:[8]

O loss of appetite **O** nausea

O problems with swallowing/chewing **O** others (please describe)_____

Can you walk without assistance?[12]

O YES **O** NO, only with assistance **O** NO, I stay in bed

How many pills and liquid medications do you take each day (total number)?[28]

O none **O** 1-2 **O** 3-5 **O** more than 5 **O** I don't know

In general would you say your health is[12]

O excellent **O** very good **O** good **O** fair **O** poor

Did anyone help you to complete this questionnaire?[9]

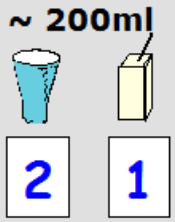
O YES **O** NO

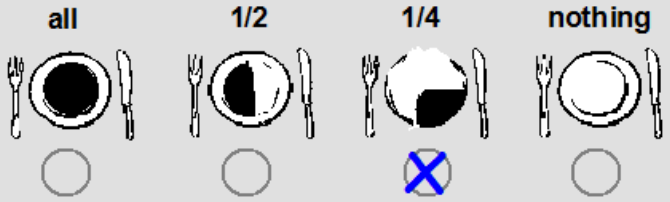
Each exponent corresponds to the numbers at the explanations.

Patient Sheet 3b **Pat.N°.**[5] ☐☐ **Initials**[4] ☐☐☐☐ **Unit**[3] ☐☐☐☐ **Date**[1] _ _ / _ _ / _ _ _ _

Please tick a circle to indicate how much you ate and drank during one meal (see example):

Example





I did not eat everything because:(please tick)

- O I was not hungry
- O I had nausea/vomiting
- O I was not allowed to eat
- O I cannot eat without help
- X I had an examination/surgery and missed my meal
- O I ordered a smaller portion

nutritionDay worldwide

[31]Number of

Drinks

Supplements

☐ ☐

What kind of drinks did you consume?[10]

- O water
- O milk
- O fruit juice
- O tea, coffee
- O soft drinks

Please indicate for one meal[29]

I did not eat everything because[12] (please tick):

- O I was not hungry
- O I had nausea/vomiting
- O I was not allowed to eat
- O I cannot eat without help
- O I had an examination/surgery and missed my meal
- O I ordered a smaller portion
- O I was tired
- O I normally eat less
- O I did not like the smell
- O I did not like the taste

This meal was[30] O **Lunch** O **Dinner**

Do you think you have your usual appetite today?[9] O **YES** O **NO**

If NO[8], O I am not hungry
O I have problems with chewing/swallowing
O nausea
O others _____

Do you eat any food apart from hospital food?[9] O **YES** O **NO**

If YES, what do you eat?[10]

- O cakes, biscuits
- O my favorite dish
- O fresh fruits
- O sweets
- O sandwich
- O fruit juice
- O dairy products
- O others _____

Each exponent corresponds to the numbers at the explanations.

Unit Patient list and outcome (all patients in the audit)

PLEASE KEEP locally only

Sheet N°. □□
ients" / / /

Patient's Number
Patient's C
(4 ini

OUTCOME + Date:
A = still in hospital
B = transferred to another hospital
C = transferred to long-term care
D = rehabilitation
F = discharged home
G = death
H = others

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Center Code[2] □□□□
Unit Code[3] □□□□
Outcome Date[32] □□.□□.□□□□

[33]firstname lastname date of birth or patient sticker	Initials[4] **optional**	Unit room N°[34] **optional**	Sheet 2 N°	Sheet 2 patient N°[5]	**Date hospital discharge dd/mm/yy**[35]	**Outcome hospital discharge A,B,C.....**[36]	**Readmitted?** (please tick YES or NO)[9]	**Comments**[37]
Example 	**Ma Mu**	**5**	1	1	**17.02.09**	**B**	**O** YES **X** NO	
			1	1			**O** YES **O** NO	
			1	2			**O** YES **O** NO	
			1	3			**O** YES **O** NO	

Each exponent corresponds to the numbers at the explanations.