Please mark the correct boxes that apply to your unit

nDay express UNIT SHEET

Date ☐☐ ☐☐ ☐☐☐☐

Center-Code ☐☐☐☐☐

Unit-Code ☐☐☐☐☐

1. Total number of beds in hospital ☐☐☐☐

2. Total bed capacity of the unit ☐☐☐

3. Number of registered inpatients at noon ☐☐☐

4. Main specialty (choose only one)

- ○ Internal Medicine / General
- ○ Internal Medicine / Cardiology
- ○ Internal Medicine / Gastroenterology & hepatology
- ○ Internal Medicine / Geriatrics
- ○ Internal Medicine / Infectious diseases
- ○ Internal Medicine / Nephrology
- ○ Internal Medicine / Oncology (incl. radiotherapy)
- ○ Interdisciplinary
- ○ Long term care
- ○ Neurology
- ○ Surgery / General
- ○ Surgery/ Cardiac/Vascular/Thoracic
- ○ Surgery / Neurosurgery
- ○ Surgery / Orthopedic
- ○ Trauma
- ○ Ear Nose Throat (ENT)
- ○ Gynecology / Obstetrics
- ○ Pediatrics
- ○ Psychiatry
- ○ Others

5. Number of each type of staff in the unit for today's morning shift

Medical doctors ☐

Nurses ☐

6. Is there a dietician, nutritionist or dietetic assistant available for your unit? ○ Yes ○ No

7. How do you MAINLY screen/monitor patients for malnutrition? (choose only one answer per column)

At admission

- ○ No routine screening
- ○ No fixed criteria
- ○ Experience / visual assessment only
- ○ Weighing / BMI only
- ○ Nutritional Risk Screening (NRS) 2002
- ○ Malnutrition Universal Screening Tool (MUST)
- ○ Malnutrition Screening tool (MST)
- ○ SNAQ
- ○ Other formal tool

Please specify:

During hospital stay

- ○ No routine monitoring
- ○ No fixed criteria
- ○ Experience / visual assessment only
- ○ Weighing / BMI only
- ○ Other formal tool

Please specify:

8. When do you routinely weigh your patients? (mark all that apply)

- ☐ at admission
- ☐ Within 24 hours
- ☐ Within 48 hours
- ☐ Within 72 hours
- ☐ Every week
- ☐ Occasionally
- ☐ When requested
- ☐ At discharge
- ☐ Never

9. What do you do to support adequate food intake of patients? (mark all that apply)

- ☐ Offer additional meals or in between snacks
- ☐ Offer meal choices
- ☐ Offer different portion sizes
- ☐ Consider food presentation
- ☐ Change food texture/consistency as needed
- ☐ Consider patient problems with eating and drinking
- ☐ Ensure that mealtimes are undisturbed/protected mealtime policy
- ☐ Promote positive eating environment
- ☐ Consider cultural/religious preferences
- ☐ Consider patient allergies / intolerances
- ☐ Other

THANK YOU!

Please mark the correct boxes that apply to this patient

nDay express
ABOUT YOUR PATIENT

Date ☐☐ ☐☐ ☐☐☐☐
Center-Code ☐☐☐☐☐
Unit-Code ☐☐☐☐☐

Patient number ☐☐☐
Year of birth ☐☐☐☐
Sex ○ Female ○ Male
Date of admission ☐☐ ☐☐ ☐☐☐☐
Weight ☐☐☐,☐ kg ○ estimated ○ measured
Height ☐☐☐ cm ○ estimated ○ measured
Patient consent ○ Yes ○ No

PLEASE CONTINUE ONLY IF PATIENT GAVE CONSENT!

1. This hospital admission was… ○ planned ○ an emergency ○ I do not know

1a. Diagnosis at admission (mark all that apply)

- ☐ 0100 Infectious and parasitic diseases
- ☐ 0200 Neoplasms
- ☐ 0300 Blood and bloodforming organs and the immune mechanism
- ☐ 0400 Endocrine, nutritional and metabolic diseases
- ☐ 0500 Mental health
- ☐ 0600 Nervous system
- ☐ 0700 Eye and adnexa
- ☐ 0800 Ear and mastoid process
- ☐ 0900 Circulatory system
- ☐ 1000 Respiratory system
- ☐ 1100 Digestive system
- ☐ 1200 Skin and subcutaneous tissue
- ☐ 1300 Musculoskeletal system and connective tissue
- ☐ 1400 Genitourinary system
- ☐ 1500 Pregnancy, childbirth and the puerperium
- ☐ 1600 Conditions originating in the perinatal period
- ☐ 1700 Congenital/chromosomal abnormalities
- ☐ 1800 Symptoms, signs, abnormal clinical/lab findings
- ☐ 1900 Injury, poisoning
- ☐ 2000 External causes of morbidity and mortality (e.g. transport accidents, assaults)
- ☐ 2100 Factors influencing health status and contact with health services

1b. Main reason for admission (choose only one code from above) ☐☐☐☐

2. Which conditions/comorbidities does this patient have? (mark an answer for each)

Condition			Condition		
Cardiac insufficiency	○ Yes	○ No	Diabetes	○ Yes	○ No
Myocardial infarction	○ Yes	○ No	Cancer	○ Yes	○ No
Chronic lung disease	○ Yes	○ No	Infection	○ Yes	○ No
Cerebral vascular disease	○ Yes	○ No	Dementia	○ Yes	○ No
Peripheral vascular disease	○ Yes	○ No	Major depressive disorder	○ Yes	○ No
Chronic liver disease	○ Yes	○ No	Other chronic mental disorder	○ Yes	○ No
Chronic kidney disease	○ Yes	○ No	Other chronic disease	○ Yes	○ No

3. Is this patient terminally ill? ○ Yes ○ No ○ I do not know

4. Was this patient identified as malnourished or at risk of malnutrition?
○ Malnourished ○ At risk ○ No ○ I do not know

5. Nutrition intake (TODAY) (mark an answer for each)

Regular hospital food	○ Yes	○ No	○ I do not know
Fortified/enriched hospital food	○ Yes	○ No	○ I do not know
Protein/energy supplement (e.g. ONS drinks)	○ Yes	○ No	○ I do not know
Enteral nutrition	○ Yes	○ No	○ I do not know
Parenteral nutrition	○ Yes	○ No	○ I do not know
Special diet	○ Yes	○ No	○ I do not know

6. Fluid status (TODAY) ○ Normal ○ Overloaded ○ Dehydrated ○ I do not know

THANK YOU!

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Please mark the correct boxes

nutritionDay worldwide

nDay express
PATIENT SHEET

Date
Center-Code
Unit-Code

Patient number

Please ASK the following questions DIRECTLY TO THE PATIENT!

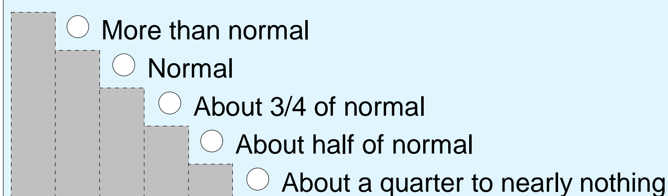
Dear Patient,
we would like to ask you to fill this questionnaire today to improve our nutritional care in the unit.Additionally, the ward staff will be providing us with some basic information about your diagnosis and treatment.Your participation is voluntary and you can withdraw at any time without any change in your current medical treatment.No personal data such as name or date of birth will be processed or saved and processing will only be in (multiple) encrypted form.
The person shown below will be very happy to answer any additional questions you may have.

Contact Person

1a. Have you lost weight within the last 3 months?
- ○ Yes, intentionally
- ○ Yes, unintentionally
- ○ No, my weight stayed the same
- ○ No, I gained weight
- ○ I do not know

1b. If yes, how many kg did you lose? ____ kg ○ I do not know

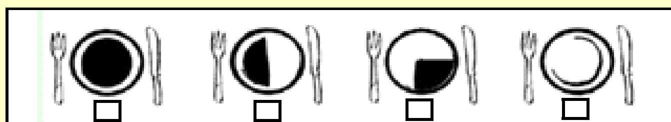
2. How well have you eaten in the week before you were admitted to the hospital?



- ○ More than normal
- ○ Normal
- ○ About 3/4 of normal
- ○ About half of normal
- ○ About a quarter to nearly nothing

3a. Please indicate how much hospital food you ate for lunch or dinner TODAY:

about all **1/2** **1/4** **nothing**



3b. If you did not eat everything of your meal, please tell us why: (mark all that apply)
- ☐ I do not have my usual appetite
- ☐ I was not hungry at that time
- ☐ I did not like the type of food offered
- ☐ I did not like the smell/taste of the food
- ☐ I was not allowed to eat
- ☐ I had an exam, surgery, or test and missed my meal
- ☐ I normally eat less than what was served
- ☐ I have problems chewing/swallowing
- ☐ I had nausea/vomiting
- ☐ I was too tired
- ☐ Other

4. Can you walk without assistance TODAY?
- ○ Yes
- ○ No, only with assistance
- ○ No, I stay in bed

5. TODAY I feel…
- ○ Stronger than at admission
- ○ Weaker than at admission
- ○ Same as at admission
- ○ I was admitted today
- ○ I do not know

THANK YOU!

Patients list and outcomes (all ND-patients)

nDay express
30 days OUTCOMES

Date								
Center-Code								
Unit-Code								

Patient Number	Discharge Date	Outcome	Readmitted since ND
		(see box 1. for codes)	(see box 2. for codes)
	10.12.2018	1	1

1. Outcome Code	2. Readmission Code
1= Still in the hospital 2= Transferred to another hospital 3= Transferred to long term care 4= Rehabilitation 5= Discharged home 6= Death 7= Others	1= No 2= Yes, same hospital planned 3= Yes, same hospital unplanned 4= Yes, different hospital planned 5= Yes, different hospital unplanned 6= Unknown

THANK YOU!