Please mark the correct boxes that apply to your institution

nutritionDay worldwide

NURSING HOME SHEET 1

Date | | | | | | | | |

Center-Code | | | | | |

Unit-Code | | | | | |

Number of residents in the unit	
Maximum number of residents in the unit	
Maximum number of residents in the institution	

Is there a dietician, nutritionist, or dietetic assistant available in this unit?

- ○ Yes
- ○ No

Is there a person in your unit dedicated to nutrition care?

- ○ Yes
- ○ No

Do you regularly screen your residents for malnutrition/risk of malnutrition? (choose only one)

- ○ Once at admission
- ○ Approx. once a month
- ○ 4 - 6 times a year
- ○ 1 - 2 times a year
- ○ Never

All residents are evaluated for malnutrition/ risk of malnutrition by: (multiple answers possible)

- ○ Body mass index (BMI)
- ○ Weight course
- ○ Monitoring food intake
- ○ Clinical view
- ○ Screening for malnutrition (MNA-SF, MUST, NRS…)
- ○ Others

Routinely, how often do you weigh your residents? (choose only one)

- ○ Once at admission
- ○ Approx. once a month
- ○ 4 - 6 times a year
- ○ 1 - 2 times a year
- ○ Never

Thank you!

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Please mark the correct boxes that apply to the resident

nutritionDay worldwide

NURSING HOME SHEET 2

Date ☐☐ ☐☐ ☐☐☐☐

Center-Code ☐☐☐☐☐

Unit-Code ☐☐☐☐☐

Consent ○ Written / oral ○ Rejected

Resident participated in the last year ○ Yes ○ No

Resident number ☐☐☐

First name (2 Initials) ☐☐

Last name (2 Initials) ☐☐

Year of birth ☐☐☐☐

Date at admission ☐☐ ☐☐ ☐☐☐☐

Gender ○ Male ○ Female

Body height ☐ ft. ☐ in.

Actual body weight ☐☐☐ lb.

Weight 3 months ago ☐☐☐ lb.

Weight 1 year ago ☐☐☐ lb.

Time needed for basic care

○ No need of care
○ < 45 min / day
○ 46 - 119 min / day
○ 120 - 239 min / day
○ > 240 min / day

Mobility

○ Bed or chair bound
○ Able to get out of bed / chair, but does not go out of unit
○ Goes out of unit

Resident is able to express himself verbally and/or non-verbally ○ Yes ○ No

Cognitive status

○ Severe dementia
○ Mild dementia
○ No dementia

Depression

○ Severe depression
○ Mild depression
○ No depression

Care causing diagnosis (multiple selection possible)

○ Cancer
○ Brain, Nerves: e.g. dementia, stroke, MS, M. Parkinson
○ Skeleton / Bone / Muscle
○ Heart, Circulation, Lung: e.g. MI, cardiac insuff., COPD
○ Others

Acute disease or psychological stress in the past 3 months? ○ Yes ○ No

Would you be surprised if this resident died in the next …

…6 months? ○ Yes ○ No ○ I don't know ○ No answer

…4 weeks? ○ Yes ○ No ○ I don't know ○ No answer

Number of current drugs / day ☐☐

Antidepressants	○ Yes	○ No
Antibiotics	○ Yes	○ No
Opiates	○ Yes	○ No
Sedatives	○ Yes	○ No
Antipsychotics / Neuroleptics	○ Yes	○ No

Malnutrition	○ Yes	○ At risk	○ No
Dehydration	○ Yes		○ No
Dysphagia	○ Yes		○ No
Chewing problems	○ Yes		○ No
Oral nutrition	○ Yes		○ No
If yes: Blenderized / pureed diet	○ Yes		○ No
Fortified diet	○ Yes		○ No
Oral nutritional supplements (e.g. sip feeds)	○ Yes		○ No
Tube feeding	○ Yes		○ No
Parenteral nutrition	○ Yes		○ No
Fluid infusion	○ Yes		○ No

Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

○ Severe decrease
○ Moderate decrease
○ No decrease

How well has the resident eaten in the last week?

○ More than usual
○ As usual
○ A bit less than usual
○ A lot less than usual
○ Nothing
○ Nothing because of tube feeding / parenteral nutrition

Please tick how much the resident ate for lunch today

○ 3/4 or all

○ 1/2

○ 1/4

○ Nothing

○ Nothing because of tube feeding / parenteral nutrition

○ I don't know

Did the resident require assistance eating their meal? ○ Yes ○ No

Thank you!

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Unit resident list and outcomes (all residents in the audit)

nutritionDay worldwide

PLEASE KEEP LOCALLY ONLY!

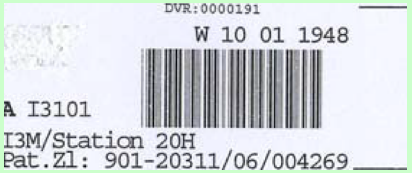
Codification
A=still in nursing home
B=transfered to another nursing home
C=discharge home
D=death
E=others

Center-Code

Unit-Code

Date of nutritionDay

Date of outcome-evaluation

		OUTCOME AFTER 6 MONTHS						
Firstname, lastname, date of birth **.. or resident sticker**	**Resident number**	**Habitation after 6 months**	**Date of transfer to another unit, death,...**	**Actual weight (lb.)**	***during last 6 months***			**Comments**
					Hosital-stays		**Number of falls**	
					number	**in days**		
					only fill in if A, D, or E applies			
	1	A	24.04.2017	75,2 kg	2	17	3	

Thank you!

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