

Hip Fracture

Client Name: _____ **#:** _____ **Initiated by:** _____ **Date:** _____

Screen
Nutrition Screen diagnosis: Hip Fracture
Signed: _____ Date: _____

Assess (Check any/all)

- Impaired mobility
- Poor strength
- Infection (eg, pneumonia, UTI, URI)
- Pressure ulcers/wounds

Weight/BMI

- Weight loss >3 lb/wk or >5%/mo or >10%/6 mo
- BMI <20 (High Risk)
- BMI >27

Dehydration

Poor Oral Intake Symptoms

- Nausea
- Vomiting
- Complex diet order
- No appetite
- Diarrhea
- Depression/anxiety

Signed: _____ Date: _____

Goals (check any/all):

- Maintain or improve mobility in _____ (goal time).
 - Maintain or improve nutritional status in _____ (goal time).
 - Increase strength in _____ (goal time).
- Weight maintained, or loss/ gain of _____ lb in _____ (goal time).

Moderate Risk Interventions
(Check any/all)

- Food Record provided and explained
- Fluid intake encouraged

Obtain Dr. orders as needed:

- RD chart consult
- Social Services chart consult
- PT chart consult
- Monitor weight q: _____
- BID/TID supplements

Other: _____
(See notes for documentation.)

Signed: _____ Date: _____

High Risk Interventions (Check any/all)

- Food Record provided and explained
- Fluid intake stressed

Obtain Dr. orders as needed:

- RD referral for home visits
- Social Services referral for home visits
- PT referral for home visits
- Monitor weight q: _____
- Monitor I & O q: _____
- BID/TID supplements

Other: _____
(See notes for documentation.)

Signed: _____ Date: _____

Assess Response (Check any/all)

- Decreased mobility
- Decreased strength
- Weight change not appropriate per goal
- Onset of new infection
- Dehydration
- Other: _____
(See notes for documentation.)

Signed: _____ Date: _____

Outcomes Achieved

- Mobility maintained or improved
- Strength maintained or improved
- Weight maintained or improved
- Hydration status maintained or improved
- Other: _____
(See notes for documentation.)
- Repeat Nutrition Risk Screen in _____ days

Signed: _____ Date: _____

Assess Response (Check any/all)

- Decreased mobility
- Decreased strength
- Weight change not appropriate per goal
- Continued dehydration
- Onset of new infection
- Other: _____
(See notes for documentation.)

Signed: _____ Date: _____

Outcomes Achieved

- Mobility maintained or improved
- Strength maintained or improved
- Weight maintained or improved
- Hydration status maintained or improved
- Other: _____
(See notes for documentation.)
- Repeat Nutrition Risk Screen in _____ days

Signed: _____ Date: _____

Outcomes Not Achieved
Reassess/evaluate need for EN/PN (refer to Tube Feeding Nutrition Care Plan). Document on Nutrition Variance Tracking form.