Learning Outcome 5: Based on the efficacy and strength of scientific evidence, collect data, assess nutrition status, determine nutrient requirements, develop and implement interventions for individuals and groups in a variety of practice-based settings, and document in appropriate records.
NUTR 6007: Grady Acute Care Supervised Practice
Artifacts: Acute Care Rotation Evaluation

Grady Memorial Hospital can be an intimidating place. At least that's how I felt when I realized I was about to begin my acute care rotation. I started this rotation feeling nervous and intimidated because I heard they placed the students on the 'prisoner floor'. Being from out-of-state I only had rumors to shape my opinion of Grady Hospital. Despite the stories, I was excited to begin this chapter of my coordinated program (CP) experience. How could I not be excited? I could wear scrubs and a lab coat and talk to people about something I am passionate about, nutrition.

My preceptor made me feel at home from day one. She was warm and inviting, had a bit of sass to her personality, and taught me everything about clinical dietetics. Between her leadership, working alongside a team of skilled RDs and my fellow coordinated program students, I gained invaluable experience.

Throughout 144 hours spread over a six-week rotation I encountered various patients in the acute setting. The majority of my patients had multiple co-morbidities and I seldom had a patient with only one health issue. The leading problems at Grady seemed to be type 2 diabetes mellitus (T2DM), chronic kidney disease (CKD) or end stage renal disease (ESRD), sprinkled with chronic heart failure (CHF), obesity, and the list goes on. It was disheartening at times to encounter patients who have numerous medical problems but were unwilling to make dietary changes or those that were unable to see the importance of nutrition. This was due to many factors including the short amount of time I was able to spend with each patient, different patients were at different stages of change, and each person had different external social situations that may have prevented them from making changes. One of my patients, Mr. H, was unlike the others and I will use him as an example of one of the many ways I utilized the Nutrition Care Process (NCP) and ADIME (assessment, diagnosis, intervention, monitoring, and evaluation) to fulfill this learning outcome.

Each morning I would come into the nutrition office to review my patient's electronic charts on EPIC (Grady's informatics system). This included looking at lab values, recent notes, any medical procedures or surgeries performed, personal medical history and family history, changes to diet orders, and other pertinent information. Afterwards, I would discuss the status of each patient I was following with my preceptor and then proceed to visit patient's that needed to be charted on or monitored. I would spend anywhere from 5-20 minutes with a patient. My visit was spent investigating nutrition habits at home, gauging education level related to their medical problems and nutrition, their social situation, and other data relevant to clinical decision-making.

After collecting significant information during an initial assessment with a patient I would determine their estimated energy, protein, and fluid needs. Individualized calculations such as Mifflin St. Jeor, KDOQI guidelines, the Nutrition Care Manual, ASPEN guidelines, and other evidence-based sources were used to determine nutritional requirements. After an assessment and needs were determined, diagnostic terminology was used in the format of a problem, etiology, and symptoms (PES) statement. The PES statement would lead to my intervention strategy including how I would implement and monitor such changes to the patient's

nutrition plan. This would include any plans and/or recommendations to make changes in food-nutrient delivery, nutrition education, nutrition counseling, or coordination of nutrition care and referring them to the outpatient RD or other healthcare professionals.

My monitoring and evaluation statement consisted of how and what I would be keeping track of to determine if my nutrition intervention was successful. This could include monitoring markers such as weight, intake, and lab values and were based on the signs and symptoms portion of the PES statement. I documented each progress note (initial assessments and follow-ups) and consult notes in EPIC where my preceptor would then cosign and order any diet changes, nutritional supplements like Boost, and/or lab values such as pre-albumin.

My preceptor mentioned in my evaluation that I experienced some difficult and complex cases during my acute rotation and that my follow-up was timely and appropriate. One example of this was with Mr. H, who came to Grady with stool via his abdominal wall fistula on his lower left quadrant (LLQ) for one-month prior to admission. His past medical history included Crohn's disease since 1989, an abscess surgery in 1991, a LLQ colostomy in 2001, and a colostomy in 2004.

When I introduced myself and began my initial assessment, I could tell Mr. H was frustrated because he felt misinformed due to various doctors telling him different things. Unfortunately, throughout his stay this would become a trend. I switched gears and gained some background information about Mr. H, including what he had been consuming at home. Mr. H informed me he was only drinking six Boosts per day and was not consuming any solid foods for fear of his fistula output. This alarmed me because he also stated he had recently lost approximately twenty pounds over the past three months without a loss of appetite. Twenty pounds sounded like a lot of weight to lose for a 6' tall, 100 pound man. Mr. H was visually wasted; his BMI was 13.6 upon admission. Drinking six Boosts per day would supply him with approximately 1,440 kcals/day and 60 grams of protein. This did not meet his estimated needs of 1550-2170 kcals (25-35 kcals/kg) and 62-93 grams of protein (1.0-1.5 g/kg) for a recommended BMI of 18.5. This is the lowest BMI recognized for a normal weight individual. My diagnosis was based off of Mr. H's weight loss of 13.4% in six weeks, temporal wasting, and decreased caloric intake; therefore he met the malnutrition guidelines as severely malnourished and had an increased need for protein and calories.

Mr. H's initial diet was ordered by a physician and included total parenteral nutrition (TPN) starting with 1L: 40 g amino acids, 150 g dextrose, and 30 g lipids, as well as a general diet order, and one Boost three times a day (TID). His TPN was adjusted to 2L: 40 g amino acids, 150 g dextrose, and 30 g lipids after the first day. My preceptor instructed me to research enterocutaneous fistulas and determine the guidelines for nutrition support with these types of patients. TPN was deemed appropriate for Mr. H according to various evidence-based research articles. Although he was a TPN patient, he still needed to consume a tolerable amount of the general diet and Boost each day to maintain appropriate calories and protein. Mr. H needed approximately 730 calories per day in addition to the 1,130 calories from TPN in order to meet his needs of approximately 1,860 calories/day (30 kcals/kg). Mr. H remained on TPN while I was at Grady, but I lowered his dextrose to 130 g/L due to his blood glucose constantly trending up.

Upon follow-up, I noticed Mr. H was not eating his general diet. He said he felt more comfortable drinking Boost. His eyes lit up as I returned with a case of Boost for him to access when appropriate, I felt like I was truly making a breakthrough and gained my patients trust.

Despite Mr. H's appreciation of my service, he remained frustrated with his physicians because he was awaiting surgery to repair his fistula and it was being pushed further and further back. He felt he was not as informed as he could be. As my preceptor mentioned in my evaluation, I interacted with physicians and other members of the healthcare team comfortably. During my rotation, I often times took the initiative to contact physicians in order to get more information when I was unable to find it in the various medical records and notes to appropriately care for my patient's nutritional needs. A dietary intervention I suggested was to add Impact Advanced Recovery (IAR) to Mr. H's daily intake. IAR is used to prepare patients for surgery. According to Nestle Health Science's website, IAR is "a unique beverage specially formulated to help support the body's nutrient needs before and after major surgery. IAR contains a unique blend of L-arginine, omega-3 fatty acids and nucleotides to support the body before and after major elective surgery." IAR must be used three times per day for five days prior to surgery to be effective.

After various conversations with physicians and surgeons, a date was scheduled for Mr. H's surgery and I determined when five days prior would be to flag that as the day Mr. H would began IAR. I had three follow-ups with Mr. H before my time at Grady was over, and I continued to monitor his progress prior to his upcoming surgery, including evaluating lab values, daily weight fluctuations, tolerance of TPN, and PO intake. I educated the patient about IAR and how it would help him build strength before his surgery and help speed up his recovery post-surgery. I evaluated his level of comprehension by having him repeat the information back to me directly after and I returned to quiz him later that afternoon to assess and confirm his retention and understanding of the information. Mr. H proved to be competent and compliant during his hospital stay.

I believe using the NCP and the ADIME format is very beneficial in nutrition practice. This format creates a systematic approach for other RDs and health professionals to read through and understand, and in turn a higher level of quality care can be provided to each patient on an individual level. My experiences during acute care at Grady allowed me to gain invaluable experience with note writing, the NCP, and utilizing an individual plan for each patient. While I was nervous to begin this rotation, I became more experienced and confident throughout my six-weeks in the acute-care setting. My preceptor mentioned in my evaluation that I was able to handle a large amount of patients and use my time wisely while maintaining good interpersonal skills with my patients. Going forward, I will be more detail oriented when working with patients in all settings, not only clinical, in order to maintain a high level of care. One of my personal goals throughout the CP is to soak in as much knowledge and experiences as possible throughout each rotation. I am happy with the progress I made during my six-weeks of acute-care and I look forward to my progression and growth as a future RD.