

Pneumonia

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

Screen
Nutrition Screen diagnosis: Pneumonia
Signed: _____ Date: _____

Assess (Check any/all)
 Increased respiratory rate/effort
 Fever/purulent expectorant
 Strength
 Dehydration
Weight/BMI
 Weight loss >3 lb/wk or >5%/mo or >10%/6mo
 BMI <20 (High Risk)
 BMI >27
Poor Oral Intake Symptoms
 Complex diet order
 Nausea/Vomiting
 Poor appetite/early satiety
 Problems chewing/swallowing
 Depression/anxiety
 GI distress
 Signed: _____ Date: _____

Goals (check any/all):

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

Moderate Risk Interventions
(Check any/all)
 Foods and Fluids for Recovery provided and explained
 Food Record provided and explained
 Fluid intake encouraged
Obtain Dr. orders as needed:
 RD chart consult
 Evaluate respiratory rate/effort q: _____
 Monitor weight q: _____
 BID/TID supplements
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

High Risk Interventions (Check any/all)
 Foods and Fluids for Recovery provided and explained
 Food Record provided and explained
 Fluid intake stressed
Obtain Dr. orders as needed:
 RD referral for home visits
 Evaluate respiratory rate/effort q: _____
 Monitor weight q: _____
 Monitor I & O q: _____
 BID/TID supplements
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Assess Response (Check any/all)
 Increased respiratory rate/effort
 Weight change not appropriate per goal
 Continued fever/purulent expectorant
 Dehydration
 Decreased strength
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Outcomes Achieved
 Improved respiratory rate/effort
 Improved strength
 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)
 Increased respiratory rate/effort
 Weight change not appropriate per goal
 Continued dehydration
 Continued fever/purulent expectorate
 Decreased strength
 Other: _____
 (See notes for documentation.)
 Signed: _____ Date: _____

Outcomes Achieved
 Improved respiratory rate/effort
 Improved strength
 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.

