WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2021 / 10
Date of Issue:	1st April 2021

Welsh Health Circular / Official Letter: N/A	**Subject:** Digitisation of Nursing Documentation – Nutritional Risk Assessment Tool
Sponsor: Jean White, Chief Nursing Officer, Welsh Government Claire Bevan, Senior Responsible Officer / Director of Quality, Safety, Patient Experience & Nursing, Welsh Ambulance Services NHS Trust	
Implementation Date: March 2021	

DATA STANDARD CHANGE NOTICE

A Data Standard Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on 18th March 2021.

WISB Reference: ISRN 2019 / 010

Summary: The introduction of a standardised digital Nutritional Risk Assessment tool to be used across the secondary care setting in Wales.

Applies to: This standard applies to all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Please address enquiries about this Data Standard Change Notice to the Data Standards Team in NHS Wales Informatics Service

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The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARD CHANGE NOTICE

Introduction

The Digitisation of Nursing Documentation project has been established with a view to delivering standardised agreed electronic nursing documentation, in support of Work stream 2 of the Prudent Healthcare Strategy. The project's first phase has been funded by the Welsh Government Efficiency Through Technology Fund (ETTF) with the aim of making an agreed first tranche of digitised nursing documents available nationally by November 2019.

One of the key success factors of the digitisation of nursing documents will be to collaboratively define and develop information data standards and patient level data that will inform current and future system developments. This will include learning from existing e-nursing documents projects and pilots across Wales. This will provide one standard set of assessments and documents with the potential to provide safe and effective care to the population of Wales irrespective of location, and improve patient, carer and staff experience. The aim is to release nurses from the administrative burden of completing paper-nursing documents to spend more time on direct patient care.

Nursing colleagues, from across all NHS Wales health boards and trusts, have identified the first set of nursing documents to be digitised for secondary care settings. Prioritised documents have been determined on where the greatest value is perceived to be attributed to patient care and nursing time.

Included in the first set of documents to be developed digitally is an all Wales Continence Assessment. This DSCN mandates the data fields and associated definitions to be collected as part of the continence assessment.

Scope

The digitised Nutritional Risk Assessment tool will be implemented across all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Developing e-nursing- documents for primary and community care settings are not in scope as these are in scope for existing programmes. The project will work closely with these programmes to ensure a consistent use of national information standards.

Actions

Local Health Boards / Trusts:

- Ensure that local processes and systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

NHS Wales Informatics Service:

- Ensure that all national systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

SPECIFICATION

Information Specification

The table below lists the Data Items and corresponding definitions and values that make up the information standard mandated by this DSCN. Please refer to Appendix A at the end of this DSCN for a more detailed specification.

User Interface Name	Field Identifier	Definition	Data Value Format (code or other value)	Value Sets
Date of Assessment	Assessment_Date	This is the date the actual risk assessment (or review) was carried out with the patient	8 digit numeric, CCYYMMDD 6 digit numeric: hh:mm:ss	
Measured,**R**eported, **E**stimated or **U**nable to weigh	Weight_Est_Act	This is to indicate whether the patients weight is measured, reported, estimated or unable to weigh	n1	1 - Patients weight measured 2 - Patients weight reported 3 - Patients weight estimated 4 - Unable to weigh patient
Measured,**R**eported, **E**stimated or **U**nable to weigh	Height_measured_reported	This is to indicate whether the patients height is measured, reported, estimated or unable to weigh	n1	1 - Patients height measured 2 - Patients height reported 3 - Patients height estimated 4 - Unable to measure patient
Weight	Weight_Loss	This is to allow the assessor to describe the patients weight loss within the last 6 months.	n1	1 - **Unitentional Weight loss** of 6 kg or more (1 stone) within last 6 months, **extremely thin or cachexic**, BMI < 18.5 kg/m2 = 7 2 - **Unintentional weight loss** 3kg (7lb) within last 6 months

				= 2 3 - No weight loss = 0
Appetite (current)	Appetite	This is to allow the assessor to describe the patients current appetite outlining their food and fluid intake.	n1	1 - **Little or no appetite** or refuses meals and drinks = 4 2 - **Poor** – eating less than a quarter (1/4) of meals and drinks = 3 3 - **Reduced** – eating half of meals = 1 4 - **Good** – eats 3 meals/day or is fully established on tube feed = 0
Ability to eat (current)	Eating_Ability	This is to allow the assessor to describe the patients current ability to eat.	n1	1 - **NBM** for more than 5 days = 7 2 - **Unable to tolerate food** via gastrointestinal tract due to nausea or vomiting, constipation or diarrhoea, difficulty chewing/swallowing due to dysphagia or mucositis = 4 3 - **Requires prompting**, encouragement or assistance to eat and drink = 1 4 - **No difficulties**- able to eat and drink normally and independently = 0
Stress Factor (for CURRENT condition. If clinical condition is not	Stress_Factor	This is to allow the assessor to describe other conditions that can impact on the patients nutrition.	n1	1 - **Upper GI cancer** - pre/post surgery, **extensive** bowel resection/**high output** stoma / fistula. **Head & neck**

listed, choose a similar condition)				cancer/surgery, both kidney & pancreatic or bone marrow transplants, mixed depth burns (>20%) = 7 2 - **Moderate surgery** e.g. cardiothoracic, kidney transplant, vascular **Malignant disease** with complication e.g. infection. **Recent multiple injuries** e.g. spinal injury/trauma, head injury, **GBS**, **bowel surgery** (uncomplicated), **liver disease** (decompensated). **Kidney** e.g. Acute kidney injury, renal replacement therapy (HD/PD). Severe infection e.g. sepsis, endocarditis, pneumonia, peritonitis. **Pancreatitis** (Acute and chronic)~~,~~ **HIV, Burns** (15-20% mixed depth) = 4 3 - **Progressive disorders e.g.** MND, MS, Parkinson's, dementia, heart failure, COPD, **Stroke,** Fractured neck of femur, inflammatory bowel disease. Uncomplicated/stable malignant disease, 10-15% mixed depth burn = 2 4 - Uncomplicated condition with no interruption in food intake e.g. MI = 0

Pressure Ulcer / Wound (if ungradable, choose higher grade/score)	Pressure_Ulcer_Wound	This is to allow the assessor to identify the condition of the patients skin or wounds.	n1	1 - **Cat 4** pressure ulcer or open abdomen = 7 2 - **Cat 3** pressure ulcer or dehisced/infected/moderate exudate wound = 4 3 - **Cat 1-2** pressure ulcer or non-healing/low level exudate wound = 2 4 -Pressure areas intact, healing or healthy wound = 0

Categories of Nutritional Risk:

0-2 Low Risk
Repeat Screening in one week or sooner if patients condition changes

3-6 Moderate Risk
Assist with meal choice
Encourage eating and drinking and assist if required
Encourage milky drinks and snacks between meals
Monitor intake on the All Wales Food Record Chart
Complete / initiate local care plans - refer to local policy
Repeat screening in one week or sooner if patient condition changes

7+ High Risk
Refer to the Dietitian & follow actions as per Moderate risk
Monior intake on the All Wales Food Record Chart
Complete / initiate local care plans - refer to local policy
Repeat screening in one week or sooner if patient condition changes

Referral to the Dietitian should be made irrespective of WAASP score if the patient:
Requires or is receiving any form or Enteral or Parenteral nurtition support
Reports the use of prescribed nutritional supplements on admission
Newly diagnosed theraputic diet e.g. gluten free, Type 1 Diabetic

If the patient requires a theraputic diet e.g. texture modified diet, potassium restriction, food allergy or intolerance - inform catering of the specific dietary need and refer to the Dietitian if the patient requires additional support

Appendix

Nutritional Risk Assessment Tool