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INTRODUCTION

Diet education for the hospitalized patient is often overlooked because no referral is made for education or the diet is related to an old diagnosis. It is sometimes difficult for the nurse to discern how much information to provide. Often patients are dealing with more urgent medical issues and cannot give full attention to learning a new diet. It is essential to let the amount of education be patient-guided to avoid overwhelming him or her. Using valuable time to teach an uninterested patient could result in missing an educational opportunity with a motivated patient. The best course of action is to:

- Inform the patient of the diet.
- Be available for questions.
- Provide basic written information.
- Verbally emphasize a few memorable key points.
- Provide contact information or refer the motivated patient to the dietitian.

After reading Nursing and Nutrition: Providing Survival Skills, the reader will be able to:

- Describe what diet education survival skills are.
- Describe the relationship between diet and weight.
- Distinguish between saturated, unsaturated, and trans fat on a cardiac diet.
- List high sodium foods to avoid on a reduced sodium/congestive heart failure diet.
- Describe the relationship between carbohydrate and blood sugar management.
- List foods to limit on a renal diet.
- List at least one way to assist patients in dealing with side effects of cancer treatment.
- List four principles of diet treatment for inflammatory bowel syndrome.
- Discuss the difference between the diets for diverticulosis versus diverticulitis.
- Identify sources of high biological protein for wound healing.
Emphasizing a few key points is the crux of this learning module. For the purpose of this experience, we are referring to these points as survival skills.

Survival skills are immediately useful, small pieces of knowledge patients can use at home. Then when he/she is medically and mentally ready, diet knowledge can be developed using the written material you have provided, and the patient can decide whether further education is desired. Complete nutritional education should be done on an outpatient basis where it is the main focus, without other urgent medical issues to hinder the learning process.

We hope you will find these survival skills useful. It is important to feel comfortable with the nutrition education you provide to your patients.

WEIGHT MANAGEMENT

Weight management and obesity are prevalent health concerns in the United States. Often physicians will attempt to address this in their patient’s care by ordering a calorie restricted or weight loss diet while the patient is hospitalized. There are multiple factors involved in successful weight management which cannot be or should not be addressed in the hospitalized patient. However, discharge instructions may highlight components of lifestyle and diet changes that can start patients off on the right foot when they return home. This information coupled with a listing of resources to explore in the outpatient setting (the dietitian’s phone number, a list of local weight management programs, etc.) can help you provide your patient with the best care possible to encourage his or her success.

The cause of overweight status and obesity cannot be attributed to a single problem or source. Genetics plays a strong role in overall body type and tendency to become overweight. Lack of exercise and a sedentary lifestyle can result in weight gain if a high caloric intake level is maintained. For example, eliminating 30 minutes of walking daily results in 100-150 fewer calories burned in a day. With no decrease in caloric consumption, this could lead to approximately a ten pound weight gain in one year. Compounding the potential risk from genetics and activity level is age and lifestyle. As people age, they tend toward changes in lifestyle which can affect eating habits. Examples of this include eating at restaurants rather than at home, schedule changes, and travel. There are some medical conditions that also contribute to weight gain. However, they are more appropriately discussed individually and are therefore beyond the scope of this educational activity.

One tool used to define obesity and its severity is correlated with disease risk - the Body Mass Index (weight in kilograms divided by height in meters squared).

<table>
<thead>
<tr>
<th>National Institutes of Health Body Mass Index (BMI) Categories</th>
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<tr>
<td>25-29.9 is overweight</td>
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<tr>
<td>30-34.9 Obesity Class I</td>
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<tr>
<td>35-39.9 Obesity Class II</td>
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<tr>
<td>&gt; 40 Obesity Class III (or extreme obesity)</td>
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Progressively increasing BMI presents greater disease risk (diabetes, heart disease, cancer, etc.). Disease risk is further increased when abdominal obesity is present. The criteria for this includes a waist circumference greater than 35 inches for women and over 40 inches for men whose BMI is in the overweight to Class II obesity categories. It is not used for BMI’s greater than 39.9 as these people are already at high risk based on their BMI alone.

The relationship between diet and weight is a simple equation. More calories in than out causes a weight increase, while more calories out than in causes a weight decrease. Therefore, the goal is to create a negative caloric balance to achieve weight loss. This can be done using diet, activity/exercise, or a combination of both.

Diet is a more realistic avenue for weight loss in most patients as it may be easier to restrict calories than to find a way (and time) to burn the equivalent number of calories through exercise. The best way to achieve initial and long-term weight loss is to apply both caloric restriction and increased exercise/activity. When you have a motivated, interested patient, a registered dietitian can create a plan that takes into consideration lifestyle, preferences, knowledge base, and activity ability. While nutrition planning is most successful in an outpatient setting where it is the focus of the patient’s visit, an initial introduction in the hospital via written or verbal information can “jump start” a patient’s desire for weight loss.

When discussing a diet plan patients should be encouraged to examine current eating habits by keeping a food record (what, when, how much, any emotional/environmental cues at the time). The record can be assessed by the patient with the help of a registered dietitian. For the patient, a visual record may make them more conscious of what and how much they are consuming. This may also help a patient identify low nutrition, high calorie foods they could eliminate from their diet. A food record is also useful in examining and readjusting portion sizes. The actual diet plan is very individualized and is the primary focus of the registered dietitian.

It is important to note that often a patient will tell you they have tried diets before that have failed. Often when you delve further into this statement you will find that they are referring to excessive restriction or fad diets. Both are unhealthy options because without proper management or information these diets can cause nutrient deficiencies. The difficulty in following some of these restrictive diets also may result in the patient’s loss of desire to make beneficial changes in eating habits. As a consequence, the patient may become frustrated and unwilling to engage in yet another weight loss attempt. By establishing a level of trust, the nurse can convey to such a patient that even small changes can yield big results. For long-term weight loss a dietitian and weight loss program are important resources. However, you can give your patient survival skills to get them thinking and trying to make changes on their own.

Weight Management Survival Skills

- Switch to calorie-free or low calorie beverages.
- Eat three to six times per day.
- Avoid fried foods, high fat meats, fast food, and whole fat dairy products.
- Increase consumption of fruits and vegetables.
- Consider replacing sugar with a substitute or decrease its use.
- Decrease alcohol consumption if warranted.
- Provide examples of portion sizes (e.g. half cup juice, 1 cup fresh fruit, 8 oz. milk, 3 oz. meat).
- Caution against fad diets.
- Discuss the value of keeping a food record.
- Provide contact information for a registered dietitian or reputable weight control program.
CARDIAC DIET

Cardiac diets are widely prescribed in the hospital setting for patients with heart disease, hypertension, myocardial infarction, hyperlipidemia, and dyslipidemia. A cardiac diet can be part of a plan for either treatment or prevention of cardiovascular disease. In general, it consists of foods the patient may classify as healthy.

The cardiac diet increases consumption of fruits and vegetables, whole grains, and fiber and decreases consumption of fats and sodium. The diet prescription for long-term management may need to be adjusted depending on the goals of the diet or the diagnosis. A referral to a dietitian is recommended for outpatient diet evaluation and education.

The usual cardiac or heart healthy diet prescription follows the guidelines of the National Cholesterol Education Program which include:

- Total fat 25-35% of daily calories
- Saturated fat less than 7% of daily calories
- Monounsaturated fats up to 20% of daily calories
- Polyunsaturated fats up to 10% of daily calories
- Trans fat kept at a low intake
- Cholesterol less than 200 milligrams per day
- Carbohydrates 50-60% of daily calories
- Fiber 20-30 grams per day

A brief explanation of the different fats may be beneficial when dealing with patient questions. Dietary fats, particularly saturated and trans fats, can contribute to increasing total cholesterol, low-density lipoproteins (LDL), and triglycerides, which can cause plaque build-up on the blood vessel walls, decreasing the size of the blood vessel lumen. Restriction of the blood vessels increases the load on the heart because it needs to pump harder to get the blood through smaller openings.

Saturated fats are found mainly in animal products. They are termed “saturated” because on the molecular level they contain all single bonds. Unfortunately, this type of fat has been shown to increase low-density lipoprotein levels (LDL), which are associated with increased heart disease risk. Unsaturated fats contain double bonds and are encouraged in place of saturated fats because they help decrease LDL levels.

The newest addition to the identified fat family is the trans fat. Trans fat found its way into the spotlight because it has been shown to increase LDL and decrease high-density lipoproteins (the good blood cholesterol). As of January 2006, law requires that the trans fat content of foods be listed on the nutrition facts panel. This fat, found often in processed foods, is formed when hydrogen atoms are added to unsaturated fat to, in a sense, saturate them and create a solid product. Processed foods often contain these fats because they increase the shelf life. In the past there has been no dietary recommendation for trans fat. The most recent recommendation from the American Heart Association is to “limit…trans fat to less than 1% of daily calories” (Lichtenstein et al., 2006).

Sodium is restricted due to its tendency to increase blood pressure, as well as for its negative effect on the diuretic properties of some medications. Sodium is often restricted to 2,000-4,000 mg per day, depending on the diagnosis and medical plan of care.

In addition to fat and sodium restrictions, cardiac diets in the hospital may contain a caffeine restriction of 0-2 caffeine-containing items per day. Caffeine is a stimulant and can increase heart rate.
A cardiac diet takes into consideration both the benefits of restricting some food components as well as increasing consumption of healthy foods and food components.

**Cardiac Diet Survival Skills**

For more individualized diet prescription guidelines that what is listed below, encourage the patient to contact the registered dietitian after hospital discharge.

- Avoid high saturated fat foods such as bacon, high-fat red meats, luncheon meats, fatty dairy foods (cheeses, Vitamin D whole milk), and some bakery products/candy.
- Limit dietary cholesterol by decreasing consumption of red meat to no more than three times per week, choosing low fat dairy, and limiting egg yolks.
- Review food labels for amount of trans fat and choose products with 0 grams listed. Keep in mind that if a product contains less than .5 grams, the manufacturer may round it down to zero. If you are trying to strictly limit trans fat, review the ingredient list. Hydrogenated or partially hydrogenated in the list may mean it contains less than .5 grams of fat rather than zero.
- Replace butter or some margarines with a trans fat-free margarine.
- Avoid adding salt. Limit salty snack foods, and review food labels for less than 140 milligrams of sodium for most foods consumed.
- Increase fruit and vegetable consumption.
- Add fish (non-fried) to your diet.
- Look for products that contain plant stanols, as found in certain margarines and yogurts.

**CONGESTIVE HEART FAILURE**

“Heart failure is a condition in which cardiac output is inadequate to meet the body’s needs” (CareNotes system, n.d.). Increasing demands on the heart result in the heart being unable to meet the challenge of pumping blood throughout the body. Fluid accumulates, reducing the capacity for physical performance. Patients with advanced congestive heart failure find it difficult to perform activities of daily living such as eating, walking, and sleeping. “Heart failure management requires a careful balance of sodium and fluid intake matched with the capabilities of a patient’s heart and the diuretic therapy provided” (American Dietetic Association, n.d.). If the patient’s sodium intake is too high, he will retain fluid, making it even harder for an already overworked heart to perform. Healthcare providers can make simple dietary recommendations for meal choices at home less perplexing – especially if the patient has not yet seen the dietitian.

Limiting the amount of salt one uses in the diet is the prescribed method of dietary treatment in congestive heart failure. Sodium is usually limited to 2 grams or 2,000 milligrams. Food labels make it easy to check the amount of sodium in a product. Decreasing the amount of dietary salt helps to prevent/control the amount of fluids accumulated around the heart or in the legs. Too much fluid increases the workload of the heart and can cause high blood pressure.

As we get older our taste buds do not work as well as they used to. Therefore, the elderly often use salt to increase the taste of the food since their taste buds are not as sensitive. Also keep in mind that patients can truly be doing a great job with limiting the amount of salt and fluid in their diets. However, depending on how well their hearts are pumping, diet is not always the culprit.
Thanks to Mother Nature, sodium is present in everything we eat. Patients need to be able to make healthy choices and use foods naturally low in sodium. There are simple, unoffending changes patients can make in their diets. Once the patient is home and feeling better, he can schedule an appointment with the dietitian to review food records and have any further nutrition questions answered. The following is a list of simple diet changes one can make to improve the management of congestive heart failure.

Congestive Heart Failure Survival Skills

- Avoid using salt, or use half the amount currently used. Substitute with salt-free seasonings.
- Avoid canned soup. Homemade soup is good; commercial low-sodium soup is acceptable as well.
- Substitute fresh or frozen vegetables for canned vegetables.
- Limit the amount of convenience foods being used. Stick to fresh cuts of meats and limit processed meats.
- Limit the amount of fluids you drink and consume in foods such as ice cream, soup, and gelatin. Your physician will determine the amount of fluids you can have at home.

**DIABETES MELLITUS**

The prevalence of diabetes in our nation has escalated and is projected to increase over the next few years due to obesity. Diabetes affects adults and children alike. Hospital admissions for diabetes are also growing along with the debate over how much education to provide the patient prior to discharge.

Nurses are often left with the duty of answering questions and providing some educational survival skills on the day of discharge. Patients are easily overwhelmed while in the hospital, especially if they have just been diagnosed with a disease they know nothing about. Healthcare professionals need to be able to provide the patients with just the information they need to take home with them and survive. Once the patient is home and feeling better, full diabetic education can begin as an outpatient.

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**Diabetes Information from The CADRE Handbook of Diabetes Management**

When glucose metabolism is normal, ingested carbohydrate is broken down into glucose in the gastrointestinal tract, enters the bloodstream, and is transported into the body’s cells to be stored or used as energy immediately. Insulin is vital to this transport process. Normally, beta-cells respond to rising plasma glucose levels with an increase in insulin secretion. This secretion tapers off as blood glucose levels return to normal.

All forms of diabetes result from an imbalance between the body’s need for insulin and its ability to secrete insulin. When insulin secretion cannot meet the body’s demand, there is overproduction of glucose and decreased clearance of glucose from the bloodstream, which leads to increased levels of plasma glucose (hyperglycemia).

Newly diagnosed patients with diabetes need to understand how food intake and physical activity affect their condition. Careful balance of insulin, food, and physical activity contributes to metabolic stability in patients with type 1 diabetes. Weight loss is important for most patients with type 2 diabetes.

When a person is diagnosed with diabetes in the hospital, he will have lots of questions. The goal of the healthcare professional is to teach the patient that diabetes is a self-managed disease and there are not any foods that he cannot have. This is difficult for the patient to understand when he has just been told that he has a problem with his blood glucose. “It must be from something I ate...” is often the patient’s thought. This is not the case.

One must understand that the food is not the problem with diabetes. The food did not cause the problem – the body is not using the food the way it is supposed to and therefore the glucose from the digested food builds up in the blood instead of going into the cells where it is used for energy. The brain, whether you have diabetes or not, needs a certain amount of carbohydrate each minute just to function. So to eliminate a certain food from the diet is detrimental. Carbohydrates are the foods that, once digested, turn into energy (glucose) in our bodies. Carbohydrate foods are starchy foods, fruit, milk, and sweets like cake, cookies, soda, etc. The body does not distinguish between a bowl of cereal, a piece of fruit or a piece of chocolate cake with icing. It just knows that you gave it some carbohydrate. The amount of glucose in the body will differ depending on the serving size of cereal, the size of the fruit or the size of the piece of cake. However, once digested it is all glucose. This is the fuel that our body uses every minute of the day.

Weight management and blood glucose management work hand-in-hand. Extra weight, especially around the abdomen, makes it difficult for the body to use the energy provided to it after a meal. Portion control and consistency with carbohydrate foods at each meal is the key to managing blood glucose. One’s body quickly adapts to the carbohydrate level of the food and will expect a certain amount of carbohydrate at each meal and bedtime snack.

Always reinforce to the patient that diabetes is a self-managed disease and by taking small steps to an attainable goal the fear of diabetes can be eliminated. Each patient is different and will use a different method of meal planning. There is no such thing as a “diabetes diet” to prescribe to patients. Meal plans will be individualized once the patient is home and feeling better. Only then will the patient be able to focus on changes that need to be made in order to manage blood glucose and weight for the long-term.

Once the patient knows he has diabetes or accepts that his blood glucose management needs to change, there are a few things that he needs to know before he goes home. Quite often, this responsibility is placed on the nurse getting him ready for discharge. All he really needs to know are the survival skills, a few guidelines for the patient to start thinking about once he goes home and begins evaluating his diet and lifestyle. Let him know that the best thing he can do for himself is to practice eating regular meals about every 4-5 hours and have a small snack before bedtime. Foods to limit would be sweet foods: cake, ice cream, soda, etc. These are not off limits forever – once the blood glucose is under control, a plan can be set to gradually incorporate these foods in the diet once more. Once the patient is home and well, it is crucial for him to keep food records for the dietitian to review during outpatient counseling. It is very easy for healthcare professionals to control the patient’s diet while in the hospital, so it is important to see some food records to see how the patient eats outside of the hospital setting. There is no one way to teach diabetes management. Each person is an individual and must be taught diabetes management skills on an individual basis.
Diabetes Mellitus Survival Skills

- Do not skip meals.
- Practice eating three meals daily and space them out about 4-5 hours in between.
- Have a small bedtime snack daily.
- Start to use things like artificial sweeteners, diet soda and diet gelatin.
- Limit foods with a high sugar content until you return to see the dietitian as an outpatient. She will help you to understand how to include them in your meal planning.
- Start exercising to promote weight management if this is an area of concern.
- Keep four or five days of food records and call the dietitian at the hospital to schedule an outpatient visit for complete diabetes diet education.

RENAL FAILURE

The kidneys are the filtering system of the body. Waste products are filtered and then eliminated from the blood in the urine. The kidneys also maintain the balance of necessary substances such as water, sodium, and potassium. An excess of any of these substances can be harmful. Certain diseases, including diabetes and hypertension, can lead to a decrease in kidney function or renal failure. Depending on the type of renal failure one has, nutrition treatment will be different. Patients will look to the nursing professional to answer questions about diet, especially if the dietitian is not included in the patient’s care prior to discharge. Awareness of the difference between pre-dialysis renal failure and end-stage renal disease with dialysis and their diet implications is necessary.

Renal failure can happen suddenly (acute renal failure), but more commonly occurs gradually over time (chronic renal failure). Acute renal failure (ARF) occurs most often as a complication from a serious illness and does not require long-term dialysis. ARF is often a temporary condition and with proper treatment often can be reversed with no permanent or serious damage to the kidneys. Chronic renal failure (CRF) is a progressive loss of the kidney’s ability to excrete waste products. CRF slowly worsens and most often is a result of another disease process that damages the kidneys over time, such as high blood pressure, diabetes, autoimmune disorders such as lupus, and diseases of the heart or lungs. Unlike acute renal failure, CRF is not reversible. This gradual progression leads to end-stage renal disease, which requires long-term dialysis treatments.

The therapeutic nutrition provided will depend on the type of renal failure the patient develops. In acute renal failure (pre-dialysis) nutrition guidelines are very strict. The protein content of the patient’s diet is restricted severely until the renal labs return to normal. Sodium, fluids, potassium and phosphorus are restricted in the diet during the duration of the acute renal failure. The ultimate goal is to restore renal function and loosen these diet restrictions prior to discharge.

Chronic renal failure nutrition therapy will be the same until it progresses to end-stage renal disease and the patient starts long term dialysis treatments. Once dialysis starts, protein is no longer restricted as with ARF or CRF. Patients receive dialysis, which cleanses their blood, three times per week for at least three hours at each session. It is crucial to ensure that the patient is receiving adequate protein during dialysis to compensate for protein losses during the process. Sodium and fluids are still restricted to limit weight gain between dialysis treatments. Phosphorus is limited to avoid increased phosphorus blood levels which may interact with calcium to weaken bones. Phosphorus also has negative effects on heart tissue, blood
vessels, and lungs. Patients take phosphorus binders with meals to help rid the body of excess phosphorus. Potassium is also restricted in the diet. Excess serum potassium can negatively affect heart rhythms.

Patients have blood drawn monthly to check renal laboratory values. The outpatient dialysis dietitian will review lab results with the patient and make any necessary nutrition treatment changes at that time. During a post-discharge outpatient appointment the dietitian will review the patient’s food records and answer questions in more detail. Below is a list of nutrition guidelines to give patients prior to discharge to help them feel more comfortable with their home diet.

**Pre-Dialysis Renal Failure Survival Skills**

- Protein needs to be restricted to two ounces of meat at lunch and supper.
- Restrict milk to one-half cup per day.
- Limit sodium and high-sodium foods.
- Limit the amount of fluids consumed daily. The physician may order a fluid restriction. This could range from 1200-2000 ml (40-60 ounces) per day.
- Reduce the amount of potassium-rich fruits and vegetables consumed daily. Examples include: tomatoes, vegetable juice cocktails, sweet potatoes, bananas, melons, and oranges.
- Reduce whole grains and bran, cheese, and beans to decrease phosphorus consumption.

**End-Stage Renal Disease with Dialysis Survival Skills**

- Increase the amount of protein eaten – make sure you have meat with every meal.
- Limit sodium and high-sodium foods.
- Fluids need to be limited to the amount ordered by the physician.
- Limit high-phosphorus foods. Take phosphorus binders as ordered.
- Limit high-potassium foods.

**CANCER TREATMENT SIDE EFFECTS AND DIET**

Dietary interventions for cancer patients are designed to maintain adequate oral nutrition intake while attempting to treat or alleviate the symptoms caused by cancer or the cancer treatment. For the purpose of this educational activity, the focus is on nutrition for cancer treatment side effects rather than nutrition for cancer prevention. It is important to note that diet recommendations vary among patients depending on their symptoms and side effects.

The type of cancer, location, treatment, and side effects determine the nutrition intervention needed. The object of most cancer treatment is simple: destroy the cancer cells. Unfortunately, healthy cells often get damaged along the way and this is the source of the side effects.

Diet intervention is used to treat a multitude of cancer treatment side effects. These include:

- Weight loss
- Lack of appetite
- Early satiety
- Painful or dry mouth and throat
- Changes in taste and smell
- Nausea and vomiting
- Diarrhea
- Constipation

The objective is to minimize these symptoms and to provide adequate nutrition to keep the patient strong during and after cancer treatment. A healthcare professional’s responsibility is to encourage patients and make suggestions for achieving adequate nutrition intake. Unfortunately, dealing with these side effects can be tiring for the patient, both physically and emotionally, contributing to his or her inability to consume appropriate nutrition. Encouraging a patient to enlist the help of family and friends or mental healthcare professionals is appropriate if needed.

The following information provides guidelines and suggestions/survival skills for dietary treatment of the side effects listed earlier.

**Weight Loss**

If weight loss alone is the problem without concurrent nausea, vomiting, diarrhea, or other problems, a high calorie, high protein diet may be recommended. Keep in mind that to increase calories and protein during this time, suggestions may seem contradictory to conventional nutritional or healthy eating advice. That is because this diet is treating the specific problem of weight loss. This is a temporary diet until weight and medical condition are satisfactory.

**Weight Loss Survival Skills**

- Eat small meals often, especially if early satiety is a problem.
- If appetite is better during certain times of the day (often in the morning), try eating during this time regardless of conventional mealtime.
- Try milkshakes or commercial liquid supplements. They are a great source of nutrition that may be easier to consume.
- Do not skimp on the margarine or fats, and forego low-calorie diet products.
- Add cheese (a high calorie item with protein) to soup, stews, potatoes, vegetables, etc.
- Nuts and seeds are a great high calorie, low volume option if tolerated. They also are a good source of protein.
- Stress that no foods are off limits if they are tolerable. This means that items such as desserts, a great high calorie source, are perfectly acceptable.

**Lack of Appetite/Early Satiety**

Often a diet of six small meals is ordered to provide frequent limited volumes with the goal of increasing total intake for the day. It is also important to keep in mind that the patient’s emotional status plays a significant role in appetite levels. Recognizing this and providing the patient with emotional support or referring him/her to the appropriate mental health professional may assist with appetite problems.

**Lack of Appetite/Early Satiety Survival Skills**

- Eat small amounts often. Encourage snacking, eating every two to three hours.
- Try liquid forms of nutrition (commercial or homemade). Sometimes appetite for solids may be diminished in a patient who readily accepts fluids.
- Eat when hungry; do not wait for meal times.
- Try to make meal time a relaxed social event rather than a battle of wills. Pressure to eat often only exacerbates a poor appetite.
Painful or Dry Mouth and Throat

Mouth pain or dryness is often a result of cancer treatment. While there are medications and oral treatments to ease pain and encourage healing, eating acidic foods or foods with a firm consistency may worsen the situation. Often a soft, bland diet is the diet order of choice.

Painful or Dry Mouth and Throat Survival Skills

- Choose easy-to-chew foods such as mashed potatoes, ground meats, eggs, canned (nonacidic) fruits, oatmeal, etc.
- Limit/avoid spicy foods or acidic foods such as tomato and citrus fruits.
- Encourage good oral hygiene.
- Take small bites and cut food into small pieces.
- Use bland gravies or sauces to ease swallowing.
- Avoid hot foods.
- Drink fluid/take sips often throughout the day.
- Use hard candy and gum to stimulate saliva production.
- Discuss artificial saliva products with your health practitioner.

Taste and Smell Changes

Taste and smell are strongly linked and affect appetite. Even foods that normally have a pleasant aroma may not be appealing to the patient. There is no specific diet order for this. However, there are some suggestions that may help.

Taste and Smell Changes Survival Skills

- Avoid restaurants where many food odors mix; eat at home as much as possible.
- Have someone else prepare food when possible; avoid the kitchen area.
- Avoid foods that have a strong odor such as cabbage, tomato products, and stir-fry/Chinese food.
- Do not open foods yourself. Strong odors get trapped under lids and plastic wrap and can be overwhelming.
- Sweet foods often taste better than meats. Encourage these as calorie sources or sweeten a protein dish by cooking in orange juice or using a sweet sauce.

Nausea and Vomiting

Many of the preceding suggestions may also help when nausea and vomiting are an issue. There is no specific diet order, except when a patient has an acute bout of intractable nausea and vomiting. In that case, the diet order is a progression from clear liquids (water, juice, broth, popsicles) to thicker liquids, soft foods, and then regular foods if tolerated.

Nausea and Vomiting Survival Skills

- Separate liquids from solid meals by at least thirty minutes.
- Avoid large meals or eating past initial feeling of fullness.
- Limit fatty foods such as fried foods, high fat meats, and whole dairy products.
- Try to keep something in your stomach and avoid that empty feeling. Crackers, toast, or anything dry usually works well.
- Avoid carbonated fluids.
- If a food sounds unappealing, don’t force it.
• Try not to push foods that are normally your favorites at this time. This can make them seem unappealing later, even when nausea and vomiting are not current problems.
• Do not lie down immediately after eating.
• Avoid clothing that constricts around the stomach.

Diarrhea

When a patient has diarrhea, re-hydration with water and sodium- and potassium-containing beverages (sports drinks, fruit juices, broths) is important. The diet recommended might be low fiber, low residue, increase oral fluids. This type of diet limits the amount of material that is not easily digested, such as fiber in fruits and vegetables and the lactose (milk sugar) in milk in an effort to decrease the volume going through the colon.

Diarrhea Survival Skills

• Avoid high fiber fruits and vegetables, especially broccoli, cabbage, cauliflower, and corn. Instead, eat cooked/canned vegetables, peeled fruits and vegetables.
• Switch to white versus whole-wheat grains and cereals
• Avoid drinking milk. After the diarrhea subsides, slowly add milk back to your diet, stopping if the diarrhea returns. Temporary lactose intolerance could be to blame.
• Avoid large meals.
• Avoid caffeine.

Constipation

Pain medications may cause or exacerbate constipation. The diet ordered is usually high fiber with adequate fluid, the goal being to increase stool size and softness for easier passage.

Constipation Survival Skills

• Drink plenty of liquids, including at least 64 ounces of water per day.
• Caffeine-containing or hot drinks may stimulate a bowel movement.
• Consume high fiber foods include raw vegetables, whole grains, beans, and peas. Foods with at least three grams of dietary fiber per serving according to the food label are considered high in fiber.
• Light exercise or increased movement may help stimulate bowel movement.
• Check with your physician regarding medications to treat constipation, but be sure to continue to consume adequate fluids.

These survival skills provide basic ideas to help cancer patients in coping with treatment side effects. Ultimately, whatever works best for the patient, even unconventional food, is the best diet plan. Keep in mind that encouragement and food experimentation are the only ways to find a diet solution.
INFLAMMATORY BOWEL DISEASE

Inflammatory bowel disease (IBD) is a chronic condition with two main disease states: Crohn’s Disease and Ulcerative Colitis. Often when a patient is asymptomatic or in remission, a special diet is not needed, except for the avoidance of known triggers as identified by the patient. Diet education comes into play when a patient presents with an exacerbation of Crohn’s Disease or Ulcerative Colitis and is ready to be discharged on an oral diet. The role of the healthcare practitioner is to provide diet education, specifying foods to temporarily restrict in order to avoid further symptoms. This diet should not be overly restrictive or followed long-term. Excessive restrictions without the supervision of a healthcare provider may set the stage for suboptimal macro and micronutrient ingestion that may inadvertently create deficiencies.

It is important first to understand the differences and similarities in Crohn’s Disease and Ulcerative Colitis. Each one is site-specific in the gastrointestinal tract. Crohn’s Disease usually affects the terminal ileum, a combination of the terminal ileum and the colon, or less often, the colon only or proximal small intestine only. Ulcerative Colitis is confined to the colon. This difference in location may indicate susceptibility to certain vitamin or mineral deficiencies as determined by absorption site. For this reason, fat malabsorption and Vitamin B12 deficiency are more prevalent in Crohn’s Disease.

Both diseases represent an inflammatory process that creates symptoms of nausea, vomiting, diarrhea, abdominal cramping, and loss of appetite. Unfortunately, no specific dietary toxin or antigen has been determined as the causative factor for the diseases (Shils et al., 2005). Active inflammation may cause not only enteric loss of proteins, electrolytes, minerals, and blood, but also the complications of weight loss and nutritional deficiencies. Nutritional deficiencies most often are caused by a decrease in nutritional intake rather than gastrointestinal losses or increased caloric needs. The exception is the presence of fever or sepsis, conditions which require increased caloric intake (Shils et al.).

Four Main Principles of IBD Dietary Treatment

1. Incorporate guidelines to avoid exacerbating symptoms such as diarrhea.
2. Correct and prevent nutritional deficits, including calorie and protein deficits that have caused a decline in weight.
3. Establish a balance between diet restriction and liberalization to avoid restricting food options and thus restricting total caloric intake.
4. Coordinate diet with medical treatment to promote the healing of intestinal mucosa.

The diet progression for the hospitalized patient likely will be from an NPO (nothing by mouth) diet order, to clear liquids only, and then to a low fat, low fiber (low residue), and low lactose diet. Reducing fat will help control steatorrhea (high levels of fat in the stool) if fat digestion is compromised. Reducing
fiber will decrease mechanical irritation and the chance of obstruction if a narrowed bowel is present. This also will assist in decreasing stool frequency. Restricting lactose intake may be indicated due to temporary lactose intolerance caused by a decrease in lactase activity in the inflamed bowel.

Initial diet education survival skills are mainly provided to continue symptom control until the patient returns to his/her healthcare provider for further diet instructions. If other complications such as significant weight loss or vitamin/mineral deficiencies are present, the patient should be referred to a registered dietitian for further diet adjustment and counseling.

**Inflammatory Bowel Disease Survival Skills**

- Eat small meals/snacks often throughout the day (six small meals).
- Increase fluid intake to a minimum of 64 ounces per day if loose stools persist.
- Incorporate a general multivitamin and mineral supplement.
- Avoid milk/dairy products. Add them back slowly to monitor tolerance when bowel movements normalize and when the patient is feeling better. Initially, yogurts and cheeses usually are tolerated better than milk.
- Avoid fried and high fat meats, highly marbled or tough meats. Try lean meat such as skinless poultry, baked or broiled fish.
- Limit high fiber grains such as whole grain breads/cereals/pasta with greater than two grams of dietary fiber per serving.
- Avoid raw vegetables. Try well-cooked, skinless vegetables.
- Avoid raisins and raw fruit with peels or skins. Try juice, bananas, and canned fruits.
- Limit fats and oils.
- Avoid caffeine (CareNotes system, n.d.).
- Stress to the patient that the ultimate goal is to liberalize his or her diet as much as possible after symptoms have subsided under the guidance of a healthcare provider.

**Diverticular Disease**

Diverticular disease encompasses both diverticulosis and diverticulitis. Each condition is different, as is the diet therapy prescribed. Healthcare professionals need to know the difference between the two disease states and need to be able to answer questions appropriately before the patient is discharged from the hospital.

Most women and men have small pouches in their colon which, as they get older, bulge out of weak areas of the colon. These bulging pouches are called diverticula and this condition is known as diverticulosis. Nearly fifty percent of Americans aged 60-80 have diverticulosis – almost everyone over 80 years of age has diverticulosis. When the pouches become infected, the condition is known as diverticulitis.

The cause of the infection of the small pouches is unknown. However, it is believed that diverticular disease is mainly caused by a low-fiber diet. Fiber is the part of fruits, vegetables and grains that the body cannot digest. Fiber gives food its crunch. When fiber is missing in the diet, the food is not able to move through the digestive tract as quickly and small particles of food can get caught in the small pouches of the colon, causing them to become infected.

A high-fiber diet is recommended with diverticular disease in order to keep the food moving through the body. A high-fiber diet helps reduce symptoms of diverticulosis and keeps stool soft so it is able to
move easily through the colon. You can increase the amount of fiber in the diet by adding more 100% whole grain breads and cereals and fresh fruits and vegetables such as apples, melons, blueberries, broccoli, cabbage, spinach and dried beans. The American Dietetic Association recommends 20-30 grams of fiber daily to maintain bowel regularity.

Fiber and waste products from the GI tract are called residue (CareNotes system, n.d.). Once the small pouches become infected (diverticulitis), the dietary treatment changes to a low-residue diet in order to alleviate symptoms of the disease. Prior to discharge, healthcare professionals should provide survival skills to the patient, enabling him to function at home and to receive proper nutrition without causing further irritation.

**Diverticulosis Survival Skills**

- Choose fresh fruits and vegetables more often than juices.
- Choose whole grain breads such as 100% whole wheat, rye and bran.
- Choose cereals made from 100% whole grains such as wheat, bran or oats.
- Use brown or wild rice instead of white processed rice and in place of potatoes in meals.
- Use whole wheat flour instead of all-purpose white flour in recipes.
- Avoiding foods with nuts, seeds, or hulls may reduce the chances of food getting stuck in the diverticula.
- Use cooked lentils, dried peas and beans in casseroles, soups, etc. (Nutrition care manual, n.d.).

**Diverticulitis Survival Skills**

- Follow a low-residue diet. Fiber and waste products that remain in the GI tract after digestion are called residue.
- Limit dairy products like milk and cheese to 1-2 servings a day.
- Do not eat tough or stringy cuts of meat or deep fried foods.
- Do not eat raw vegetables or raw fruits that have skins or seeds (CareNotes system, n.d.).
- Avoid foods containing caraway seeds, nuts, popcorn hulls, and sunflower, pumpkin and sesame seeds (Nutrition care manual, n.d.).

**Wound Care**

Many patients in the acute care setting have either come to the hospital with an existing wound or develop one while there. Wounds, or pressure ulcers, begin when the skin is compressed between a bony prominence and an external surface, like a bed or chair, for an extended period of time. The most common areas for the development of pressure ulcers include the pelvic, hip and heel areas. Nutrition is indispensable in the healing process. Recognizing that certain nutrients in the diet will aid the healing process is an essential step in the care of patients with pressure ulcers (Chernoff et al., 2004). In the event that the dietitian is not able to see the patient prior to discharge, the nurse is often responsible for providing some basic nutrition information to aid in wound healing.

Extended pressure on bony areas prevents oxygen and nutrients from reaching the tissue. The tissue becomes injured and eventually dies. A blister forms over the area, eventually creating an open area in the skin (Chernoff et al., 2004). Increased protein intake has been shown to improve wound healing in patients with pressure ulcers/wounds. Protein is one of our main food sources used for cell maintenance, tissue repair, and muscle building. Often
high protein supplements are necessary to maximize the amount of protein consumed by patients with wounds. Optimal nutrition is an integral part of comprehensive wound management, and is essential to meet the increased calorie/protein needs and to decrease the use of protein as an energy source (Demling et al., 2003).

To aid in the wound healing process, dietary protein and fluids should be increased and a healthy diet must be maintained. High biological value protein comes from animal sources such as:

- Meat, fish, poultry
- Eggs, egg whites, egg substitutes
- Cheese, milk, yogurt

Additional high-protein sources to aid in wound healing include:

- Peanut butter
- Dried beans and peas
- Tofu
- Nuts and seeds

**Wound Care Survival Skills**

- Follow a balanced meal plan that includes food from all of the food groups.
- Make sure foods high in protein are included with every meal and snack. Approximately 5-7 ounces of meat daily should be adequate if the balanced meal plan includes adequate calories and at least three dairy servings per day.
- Drink plenty of fluids. Ten to 12 cups of caffeine-free liquid is recommended for wound healing unless the physician has instructed the patient to limit them.

**SUMMARY**

Nutrition is a broad topic. Learning the details of every diet is neither functional nor essential for the nursing professional. It is important, however, to have a basic working knowledge of common diets. A nursing professional has the most continuous contact with a patient during the hospital stay, and therefore is likely to have to field diet questions.

The diets and diagnoses with a nutritional impact presented in this learning module are frequently prescribed for the hospitalized patient. The information is not exhaustive and does not include all aspects and information about the diets. However, the focus is on information that is basic, user friendly, and easy to retain, thus the classification of survival skills. Authorities such as the American Dietetic Association are using the term "survival skills" as observed in the Online Nutrition Care Manual (Nutrition care manual, n.d.). Their system gives the educator the option of providing limited (usually appropriate to the hospitalized patient) or detailed (usually appropriate to the clinic/outpatient or patient with prior education) information.

The diet education goal for the patient discharging from the hospital is to provide immediately useful, small pieces of knowledge the patient can put to use upon going home. When you provide this, you provide survival skills until the patient is physically and mentally ready to take his or her diet knowledge to the next level.
REFERENCES


1) The purpose of nutrition education survival skills is:
   A. To provide the patient with 100% of his/her diet education.
   B. To provide a few important diet guidelines that they will likely remember to get started at home.
   C. To avoid overwhelming the patient with information.
   D. Both B and C

2) The cause of overweight/obesity is:
   A. Diet
   B. Genetics
   C. Lack of activity
   D. There are multiple factors involved.

3) One survival skill to discuss regarding weight management is:
   A. Caution against fad diets.
   B. Decrease meals to only one per day.
   C. Increase consumption of meats.
   D. Decrease consumption of vegetables.

4) On a cardiac diet, trans fat should be limited. Trans fat is:
   A. A type of fat that can improve your HDL level.
   B. An unsaturated fat that was altered to make a more solid product, often found in processed foods, that increases shelf life.
   C. Found only in animal products.
   D. A fat that had hydrogen atoms removed.

5) A patient asks you for a general recommendation on how often to eat red meat on his/her cardiac diet. Your response is:
   A. No more than three times per week.
   B. No more than once per month.
   C. At least 10 times per week.
   D. Never, there is no room in your diet for red meat.

6) A diet for congestive heart failure may limit:
   A. Salt
   B. Protein
   C. Fluid
   D. Both A and C

7) The following is NOT a high sodium food:
   A. Canned chicken noodle soup
   B. Bologna
   C. Fresh cut of steak, no seasonings
   D. Salt
8) Full diabetic education is best provided:
   A. As an outpatient, once the patient is home and feeling better.
   B. Right before they leave the hospital.
   C. As soon as they are admitted to the hospital.
   D. During the course of the hospital stay, regardless of their medical condition.

9) Survival skills to provide at discharge on a diabetic diet include:
   A. No meal skipping.
   B. Limit sweets and regular soft drinks.
   C. Keep food records.
   D. All of the above

10) A renal diet may include the restriction of:
    A. Sodium
    B. Potassium
    C. Phosphorus
    D. All of the above

11) The following food is considered high potassium:
    A. White bread
    B. Canned tomato products
    C. Soda
    D. Pasta

12) The object of diet intervention during cancer treatment is to minimize symptoms and provide adequate nutrition to keep the patient strong during and after cancer treatment.
    A. True
    B. False

13) For a cancer patient who lacks an appetite, you should encourage him to:
    A. Eat whenever you feel hungry, regardless of meal time.
    B. Push/force yourself to eat, you have no choice.
    C. Eat large amounts, whether or not you are hungry.
    D. Avoid eating anytime other than conventional meal times.

14) A patient undergoing chemotherapy is complaining of food odors making him sick. You tell him to try:
    A. Avoiding restaurants where multiple food odors intermix.
    B. Have someone else do the food preparation and avoid the kitchen.
    C. Do not open foods that are in plastic wrap or containers with lids.
    D. All of the above are good tips to try.

15) Inflammatory Bowel Disease includes:
    A. Colon cancer
    B. Crohn’s Disease
    C. Ulcerative Colitis
    D. Both B and C

16) The following is NOT a principle of diet treatment for IBD:
    A. Tight diet restriction and elimination of many foods in the diet.
    B. Incorporating guidelines to avoid exacerbating symptoms.
    C. Correct and prevent nutritional deficits.
    D. Promote the healing of intestinal mucosa.
17) Patients with diverticulosis or diverticulitis should both follow a low fiber, low residue diet.
   A. True
   B. False

18) Which of the following is not considered a high fiber food?
   A. Fresh fruits and vegetables
   B. Bran cereals
   C. Orange juice
   D. Baked beans

19) The most important nutrient in wound healing is:
   A. Fat
   B. Protein
   C. Carbohydrate
   D. Calcium

20) High biological value protein includes comes from:
   A. Fish
   B. Eggs
   C. Milk
   D. All of the above
Your opinion is important to us. Please answer the following questions by circling the response that best represents your experience.

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<th>COURSE OBJECTIVES &amp; CONTENT</th>
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* If you responded “No” to question 10, please explain why:

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* If you answered “Yes” to question 11, what change do you intend to make?
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What barrier, if any, may prevent you from implementing what you learned?
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Cite one new piece of information you learned from this activity:
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Additional comments/suggestions:
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With my signature I confirm that I am the person who completed this independent educational activity by reading the material and completing this self evaluation.

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