Name | Questions	RD Role?	Important considerations when prioritizing patients/clients?	Recall a time when you struggled to prioritize multiple conditions within a patient/client. How do you prioritize what should be tended to first?	Recall a time when you struggled to prioritize between several acutely ill patients. Are there any "red flags" when looking through a patient roster or a client list?	How do you determine if patients can be seen tomorrow if you running out of time for the day? Can referrals be left till the next day as well?	Is there an effective method or way of charting that helps you efficiently prioritize?	Would you do any of the above differently on Thursday/ Friday to prepare for the weekend as there is usually no RD on site? (most healthy authorities)
Amanda Turner	- Residential Care - Rehab Program (Pathways to Home) - Acute Care (Pondarosa – Interior Health)	- workload dependant - diagnosis/ reason for visit - co-morbidities - diet type and texture - nutrition support (higher priority) - discharge is pending but no nutritional clearance/ education yet (higher priority) - referral source	- example: education for patient with heart failure, diabetes and chronic kidney disease – by looking at their diagnosis/ reason for visit we might have some conclusions but when you talk to the patient their priority might be totally different - should determine priority with the patient	- tools with different healthy authorities and units to decipher who is higher priority - if their discharge is dependent on your involvement - on nutrition support and have concerning lab values (e.g. refeeding) - NPO 5 days + - diagnosis will cause nutrition risks (bowel obstruction, esophageal CA stroke w/ failed swallowing assessment, newly diagnosed diabetes)	- no "hard and fast" rule - consider red flags (2+ can't wait for tomorrow) - if you know patient has scheduled appointments still tomorrow things like education can wait till tomorrow - referrals' urgency depends on the reason for consult and source of consult ⟶ still need to prioritize the same	- everyone has their own style - quick look through for "red flags"	- Yes! Work harder on other days to make Fridays less crazy - nutrition support: ⟶ want to increase to goal: start as early in the week to decrease complications of rate change over the weekend ⟶ consult to start Friday: start at a low rate, no progression, labs ordered, monitor set in place (goal: low risk – reassess on Monday for a detailed plan) - education needed Friday afternoon: brief conversation, give simple resources and refer to community RD or Health Link
Angel Luk	- Bariatric Surgery – Outpatient (VCH) - Contract Sport Nutrition (Richmond Olympic Oval) - previous ICU experience	- not applicable in an outpatient setting as to who you see first (scheduled appointments) - casual experience: program specific responsibility (PSR) guidelines dictate high, medium and low priority of a particular area - be realistic with your time - know how long you will need with each type of patient condition	- example: bariatric surgery referred but already undergoing HD and has long standing diabetes ⟶need to know all the goals for surgical readiness (measurable: BMI, BG, A1C, and weight and non-measurable: healthy eating techniques specific and their understanding to their surgery) ⟶ be in contact with renal RD to see their status there (especially post-op ⟶ might have conflicting information)	- ICU – team as a whole determines the person who is sickest gets seen first (Intensivist determines) - reality is the top 3 sickest gets seen first then since everyone is so critical that it's just where their bed is placed - surgery – TPN patients urgent (see patients to order bags before 10am so bags can be made by 4pm to be hung) - red flags ⟶ acute patients who are discharged soon, admitting diagnosis is pertinent to GI (e.g. Chron's and Diverticulitis), need education for diet (advocate the need)	- outpatient – not applicable but if you are running behind you still need to see everyone before you leave - follow PSR for the area (very specific guidelines)	- data assessment and plan (DAP) method - plan part remind of the next priority ⟶ good to look at for the next patient visit (don't need to re-read full assessment) - practice a good short hand (write down key words and formulate after ASAP for charting)	- outpatient – not applicable because we are not open - acute – Thursday determine the "must sees" for Friday and Friday "must sees" would be people who will D/C over the weekend ⟶ need to see before you leave no matter how late (diet teaching, TPN needs, EN adjustment) ⟶ could leave standing orders for progression for patients who should be progressing over the weekend (might write up to Monday's order so you don't rush on Monday) - need to see patients who are pending discharge based on RD
James Song	- Medical/Surgery Ward & Hep C (RH) - HIV Outpatient (Gilwest Clinic)	- look over patient census for the day and prioritize based on the unit's prioritizing guidelines (PSR - low, medium & high) - high examples are TF, TPN, AKI, education pending discharge... (should be seen within 24 hours) - medium priority within 2-4 days	- example: patient with UTI, sepsis, AKI, CHF and fatty liver ⟶ choose conditions you can change nutritionally (would tend to AKI first ⟶ electrolytes like potassium is high we could put them on renal or low K+ diet) – AKI more acute but CHF and fatty liver needs more long-term care (medical team and doctor will be on top of conditions as well)	- patients who are NPO (several days) are a red flag (Why can't they eat even after a few days? (e.g. after bowel surgery) Why are they not tolerating a fluid diet even? ⟶ possibly an ileus, might need TPN, not GI might need TF) - new transfers with TF to my unit (need to know their case)	- medium or low priority patients can be seen the next day - consults should usually be at the top of your priority	- number 1, 2, 3 (high, moderate, low priority respectively) on the census to denote who should be seen (also circle and underline) - label everyone so you can go down the list if one patient is busy or their chart is missing - end of the day transfer patient information on to Computrition (Food Service/ Nutrition Care software used at some sites) so	- Monday is usually busy with the most turn over because there was not weekend coverage - Friday should prepare for weekend (e.g. writing TF, TPN or diet requisitions changes in advance ⟶ approved orders) - bigger hospitals have on call coverage for RDs (advise over the phone – TPN and general pager for on call)

						if the patient transfers the next RD has notes	
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Karalee Boschung	- Casual dietitian with Vancouver Island Health Authorities (sees a variety of patients) - at 8 different facilities (3 acute care and 5 complex/LT care)	- nutrition prioritizing tool provided by health authority - discern nutrition risk and how much the intervention will make a difference in short term (e.g. see NPO patient who needs TF higher priority than a patient who isn't eating well but is still eating) - admission diagnosis e.g. pressure ulcer (haven't eaten for 3 days it could get worse), esophageal CA or stricture (won't have any nutrition) → these are higher priority than patients with higher nutrition needs but still eating	- resource: hierarchy of food needs by Ellyn Satter - example: alcoholic with multiple organ failure → liver failure: high protein, kidney failure: moderate protein (decided kidney was more acute)	- first see patients who are not having nutrition at all then see patients who are having nutrition but not optimized diets - day and time of discharge is important too if they need education before they leave	- if say there are 3 unseen higher priority patients left at the end of the day → decide their levels of nutrition risk or malnutrition (SGA, weight loss, BMI) to see if it is urgent - will learn through experience, clinical knowledge and intuition - ask "What will happen if I don't see them today?" (few things can't wait 24 hours)	- patient list with diets (roster/census) → write down short list of who to see for today (hard copy/ not interprofessional) - copy over information onto the new sheet tomorrow (e.g. patients who I didn't see yesterday so I need to see them today) - use highlighter to flag priority - this method is used for hand over	- Thursdays and Fridays are higher pressure so the working pace needs to be faster - sometimes changes my intervention with patients (e.g. patient on a renal diet and could possible transition to DAT over the weekend but wouldn't change the diet → can watch labs for a few days after the change)
Karen Parinas	- Renal HD Outpatient (VGH)	- patient safety and well-being - bloodwork abnormalities (diet related e.g. high potassium) - malnutrition risk factors (e.g. unintended tissue weight loss, poor appetite, limited intake, and fluid overload related to excess fluid intake)	- imposing too much and an over restrictive diet can be detrimental - in renal, often see diabetes, heart disease, and gout which require diet therapy, as well as other co-morbidities associated with the elderly such as arthritis and mobility issues that impact ability to shop, prep and cook meals. Our job is to nourish; improve or maintain nutrition status - prioritize in consultation with the patient (what is meaningful to them?)	- in my setting the patients are not acutely ill - we also have 4 dietitians to share the workload → not applicable but still follow principles of improving or maintaining nutrition status	- planned dialysis 3 times a week - if little kidney problems before and little exposure to kidney care education prior to dialysis; would need to see because they are new - address urgent concerns as per "important considerations" question - non-urgent concerns can wait (address them during daily rounds)	- form templates work best for me - have a framework for a comprehensive nutrition assessment and monitoring	- not applicable as dialysis schedules are set
Kelly Picard	- Outpatient - Diabetes Nephropathy and Renal Insufficiency Clinic (Alberta Health Services)	- prioritizing and screening takes the form of triaging patients for urgency in regards to initial appointment dates and follow up - blood works e.g. blood sugar, blood potassium - weight history e.g. weight loss	- tend to the problem that poses a greater risk of mortality (death) first e.g. malnutrition - a potassium diet restriction will supersede a dietary recommendation for diabetes	- not applicable – no acutely ill patients	- not really applicable as scheduled appointments usually never get delayed to the next day - prioritize items which needs to be addressed first (not everything needs to be discussed with every visit)	- we chart online → always attempt to do all charting live time with a patient so you don't get behind or confused	- our clinic is closed on weekends. If a patient has a medical issue on the weekend they are instructed to contact Health Link, their family doctor or an emergency room - changing medications or insulin, we may wait until Monday before implementing