Documentation Guidelines: Dietitians

Site Applicability

All VCH & PHC sites

Practice Level

Registered Dietitian (RD) – Basic Competency

Requirements

Registered Dietitians will follow regulatory body requirements, organizational policies and program guidelines when documenting in the client's health record. Temporary registrants must sign all documentation with RD(t) designation.

Dietitians must document consent, nutrition assessment, diagnosis, intervention, monitoring and evaluation and screening notes in the medical record as outlined by the College of Dietitians of British Columbia (CDBC) Standards for Record Keeping.

Dietitian documentation meets the requirements as outlined in the VCH/PHC Documentation Policy for the following:

- Accuracy
- Clarity
- Comprehensiveness
- Timeliness
- Privacy and Security
- Dietitian Signing and Co-Signing Requirements
- Signing the Signature Record (paper chart only)

The ADIME (Assessment, Diagnosis, Intervention, Monitoring and Evaluation) process is the required approach for documentation of initial assessments, follow-up/progress notes and screening notes. It is important to ensure client-centered language that is objective, observational and non-judgmental.

Need to Know

This guideline provides details specific to dietetic documentation practices and processes.

In order to appropriately document nutrition assessments and nutrition care plans, dietitians must have a comprehensive understanding of the VCH/PHC Documentation Policy and the Dietitian Ordering Guideline.

Guideline

The dietitian, using approved dietitian documentation tools, including forms, electronic health record templates and/or program-specific interdisciplinary tools, will document the following:

Consent

Consent for each visit and task (i.e. assessment and/or intervention), whether verbal or implied by gesture, will be obtained and documented as outlined by the CDBC Consent to Nutrition Care Guidelines.

Nutrition Care Process (NCP)

Using a patient centered approach, the ADIME (Assessment, Diagnosis, Intervention, Monitoring and Evaluation) format is required for documentation of initial assessments, follow-up/progress notes and screening notes.

Assessment (A): All relevant data pertaining to clinical situation/clinical decision making as well as patient/client choices and goals. See Nutrition Assessment snapshot in eNCPT.

Diagnosis (D): Problem, Etiology (root cause) and Signs and Symptoms (PES) statement is used to communicate nutrition diagnosis. See Nutrition Diagnosis snapshot in eNCPT. It identifies the main nutrition-related problem(s), and may include:

- More than one diagnosis
- The most pertinent problem(s) or only those you plan to address with nutrition interventions
- "No nutrition diagnosis at this time" for screening notes

Intervention (I): Indicate intervention(s) or recommendation(s) to address etiology of the nutrition-related problem(s) (i.e**.,** what you recommend or plan to do to address the PES statement). The interventions can also aim to alleviate signs and symptoms of the nutrition diagnosis. See Nutrition Intervention snapshot in eNCPT. Nutrition interventions may include:

- Identify Nutrition Intervention Goal(s)
- Nutrition Prescription
- Food and/or Nutrient Delivery
- Nutrition Education
- Nutrition Counseling
- Coordination of Nutrition Care by a Nutrition Professional
- Population-Based Nutrition Action

In a screening note, the nutrition intervention should be "None", otherwise a full assessment is likely warranted.

Monitoring and Evaluation (M/E): Plan for follow-up; how to determine if the patient has achieved or is progressing towards their goals; usually based on 'signs and symptoms' of PES statement. See Nutrition Monitoring and Evaluation snapshot in eNCPT. Nutrition monitoring and evaluation may include:

- Follow-up questions/comprehension of diet information
- Follow-up calorie counts (intake)
- Monitoring of weight, labs and/or clinical symptoms
- Timeframe for rescreening

Discharge Summary, Transfer Summary and Referral Forms

The discharge or transfer summary and referral form is a communication tool for the healthcare team as well as for the client and family during transitions in care and may include the following:

- Relevant data about the clinical situation/clinical decision making (i.e. anthropometric data, current diet or tube feeding schedule)
- The main nutrition-related problems (i.e., the client's status at discharge or transfer, Subjective Global Assessment (SGA) rating and nutrition diagnosis)
- The client's nutritional goals and the progress made thus far
- Education and/or education materials the client has received
- Identified needs for services
- Assessments, transfer forms or summaries to assist the client's healthcare team (e.g., Transfer Information for Enteral Feeding and VCH Home Health Dietitian Referral Form)
- Dietitian contact information
- Client main contact information

Dietitian Orders

Dietitians may place orders to facilitate nutrition interventions as part of nutrition care plans. Dietitians must document orders as outlined in the Dietitian Ordering Guideline.

Documentation Requirements

Student Documentation

- Dietitians will obtain and document client consent for student participation
- Dietetic students will follow dietitian documentation guidelines under the supervision of the preceptor
- Dietetic students are authorized to document in the client's medical record
- If the preceptor has been present for the client interaction and agrees with the note, the preceptor co-signs the note
- If the preceptor has not been present for the client interaction, the preceptor reviews the documentation and co-signs to indicate that they agree with the plan or the preceptor adds an addendum
- Documentation will be signed with name and "Dietetics Student"
- Dietetic students cannot independently place orders for diets, enteral feeding and multivitamins and minerals.

Text, Email and Video Communication

Text, email and multimedia messages of significance as well as client care provided via telephone or video conference must be documented in the client's health record following usual documentation requirements.

Once documentation in the client health record has been completed, the text, email, and multimedia messaging history and any personal and confidential information must be deleted from the mobile device.

Refer to VCH/PHC guidelines related to texting, email and video communication with clients and visitors.

CST Cerner

Interactive View (iView):

The dietitian will document, at minimum, the following information in the appropriate iView section during initial assessment, and follow-up assessment as appropriate.

- Consent
- Reason for Assessment
- SGA Rating
- Nutrition Diagnosis
- Nutrition Interventions

Dietitian practice areas may have additional unit/ward-specific iView entry requirements. Please refer to position guidance documents.

Dynamic Documentation (DynDoc) Templates:

1. "Nutrition Care Plan – Initial Note" template
   - To be used for all comprehensive nutrition assessment notes
2. "Nutrition Care Plan – Follow Up Note" template
   - To be used for comprehensive nutrition follow-up notes
3. Free Text Note
   - Can be used for short screening notes
   - Free text note naming must include the word "Nutrition", the nature of documentation and service or acuity (if appropriate). E.g., "Nutrition Screening Note".
   - All free text notes are required to be structured using ADIME
   - Temporary dietitian registrants to add name followed by "RD(t)" at end of DynDoc note.

Student Documentation in Cerner:

Preceptor sign-off is required before student documentation becomes a final report in the chart.

Preceptors are alerted to student documentation through Message Centre or direct communication with the student. Student documentation in Cerner is a two-step process with the preceptor reviewing and co-signing student documentation at two key points:

1. After data is entered in iView by student; preceptors must authenticate ( ) student documentation in iView before it can be pulled into student DynDoc templates.
2. Student to create a DynDoc, add "Dietetics Student Note" following "Nutrition Care Plan – Initial Note or Follow-up Note" to the note title.
3. At end of the DynDoc note, student to add their name followed by "Dietetics Student".
4. Preceptors must review and sign student notes within 1 working day. If student note is not signed off within 72 hours, it appears in the patient chart as a "Final Report" noting that it was "auto signed, content not reviewed".

5. If preceptor does not agree with the student note and corrections are needed, discuss with the student and have them amend the note. If unable to discuss with the student, the preceptor can then refuse the note and document a new note.

PARIS Documentation (Home Health)

1. "Interdisciplinary Assessment" (IA) template
   - To be used for all comprehensive nutrition assessments if the dietitian is the **ONLY** discipline involved in the clients' care.
2. "Clinical Assessment" in the Case Note tab
   - To be used for all comprehensive nutrition assessment notes.
3. "Clinical Care Plan" and "Back Up Plan"
   - To be used for documenting nutrition interventions, monitoring and evaluations plans.
4. "Follow-up Case Note Ongoing Care" or "Follow-up Case Note Discharge Note"
   - To be used for comprehensive nutrition follow-up notes or short screening notes.

Other Documentation Platforms (e.g., Profile EMR, Point Click Care, etc.)

All notes are structured using the ADIME format. Dietitians may choose to create a documentation template based on the guidelines and ADIME format listed above and must include, at minimum, the following information:

- Nutrition Assessment:
  - Consent
  - Reason for Assessment
  - SGA Rating
- Nutrition Diagnosis
- Nutrition Interventions
- Nutrition Monitoring & Evaluation

Related Documents

- Consent to Nutrition Care (CDBC)
- Nutrition Assessment snapshot (eNCPT)
- Nutrition Diagnosis snapshot (eNCPT)
- Nutrition Intervention snapshot (eNCPT)
- Nutrition Monitoring and Evaluation snapshot (eNCPT)
- CDBC Standards for Record Keeping

VCH and PHC

- Allergy Documentation Policy (VCH/PHC/PHSA)Nutrition Diagnostic Terminology
- Consent to Health Care Policy (VCH/PHC)
- Dietitian Ordering Guideline
- Documentation Policy (VCH/PHC/PHSA)

- Emailing Policy (VCH/PHC)
- Emailing Guidelines (VCH/PHC)

VCH

- FaceTime use – Clinical
- Paper/Electronic Documentation Standards (Vancouver Acute/Richmond) (D-00-05-30023)
- Recording (Photographing, Video Recording and Audio Recording) by Clients and Visitors
- Social Media, Websites and Online Communication
- Texting Policy
- Video Visit Guidelines
- Zoom Application Use Guideline

PHC

- Cellular Phones and Smartphones
- Documentation Policy
- Texting Policy

References

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2. Documentation Policy. (2018). Retrieved 3 May 2021, from http://shop.healthcarebc.ca/CST_Documents/CSTDocumentationPolicy.pdf
3. Electronic Nutrition Care Process Terminology (eNCPt) Retrieved 31 October 2022, from https://www.ncpro.org/modules/portal/publications.cfm
4. Integrated Competencies for Dietetic Education and Practice (ICDEP). (2020). Retrieved 3 May 2021, from https://www.pdep.ca/library/PDEP-Policies/Integrated-Competencies-For-Dietetic-Education-And.aspx
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	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
	Practice Consultant, Professional Practice Dietitian PPL, PHC Dietitian PPL, PHC	**Development Team member(s):** Dietitian Practice Leader (VA and VC) Dietitian Practice Coordinator (VA) Dietitian PL (Richmond) Dietitian Practice Coordinator (Coastal and VC)