

 <p>Winnipeg Regional Health Authority Office régional de la santé de Winnipeg Caring for Health À l'écoute de notre santé</p> <p>BEST PRACTICE GUIDELINE</p>	<p>NUTRITION & FOOD SERVICES Clinical Nutrition</p>	<p>Number:</p>	<p>Page: 1 of 8</p>
	<p>Name: Nutrition Assessment Health Record Form Guidelines – Pediatric Ambulatory Care</p>	<p>Approved by: Kathleen Richardson Chief Nutrition and Food Services Officer</p>	
	<p>Date: December 2012</p>	<p>Supercedes:</p>	

1.0 **PURPOSE:**

- 1.1 Communicate nutrition assessment to health care team.
- 1.2 Facilitate comprehensive nutrition documentation to meet medical legal documentation requirements and practice standards.
- 1.3 Standardize nutrition documentation forms across sectors for inpatients, residents, and community/ambulatory care areas.

2.0 **DEFINITIONS:**

- 2.1 **Nutrition Assessment** is the first step of the Nutrition Care Process. Its purpose is to obtain adequate information in order to identify nutrition-related problems. Nutrition assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. Nutrition assessment requires making comparisons between the information obtained and reliable standards (ideal goals). Assessment provides the foundation for the nutrition diagnosis.
- 2.2 **Nutrition Diagnosis** is the second step of the Nutrition Care Process, and is the identification and labeling that describes an actual occurrence, risk of, or potential for developing a nutrition problem that dietetics professionals are responsible for treating. Data are clustered, analyzed and synthesized to reveal a nutrition diagnostic category.
- 2.3 **Nutrition Intervention** is the third step of the Nutrition Care Process. An intervention is a specific set of activities and associated materials used to address the nutrition-related problem. Nutrition interventions are purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition or aspect of health status for an individual, target group, or the community at large. This step involves a) selecting; b) planning, and c) implementing appropriate actions to meet client nutrition needs. The selection of nutrition interventions is driven by the nutrition diagnosis and provides the basis upon which outcomes are measured and evaluated.

Dietetics professionals may actually do the interventions, or may include delegating or coordinating the nutrition care that others provide. All interventions must be based on scientific principles and rationale and, when available, grounded in a high level of quality research (evidence-based interventions).

Nutrition intervention is directed, whenever possible, at the etiology (PES statement). Otherwise, it should be directed at reducing impact of signs and symptoms.

- 2.4 **Nutrition Monitoring and Evaluation** is the fourth step of the Nutrition Care Process. Nutrition monitoring and evaluation identifies client outcomes relevant to the nutrition diagnosis and intervention plans and goals. The change in specific nutrition care indicators, through assessment and reassessment, can be measured and compared to the client's previous status, nutrition intervention goals, or reference standards.

3.0 **PRACTICE GUIDELINES:**

- 3.1 Registered dietitians are to complete the Nutrition Assessment form as per the following procedures:

4.0 **PROCEDURE:** (when applicable)

- 4.1 All standard client identifier information needs to be documented in top right hand corner (e.g. patient health record number, date of birth, provincial health care number, doctor, clinic/unit or location).
- 4.2 Check off initial assessment if the client is a new admission or new consult/referral. Check off reassessment for the following: scheduled review, or complete nutrition assessment required due to change in status.

Record weeks gestation or "term". Record chronological age. Record corrected age or "N/A".

4.3 **NUTRITION ASSESSMENT DATA**

The first page of the form pertains to the identification of data elements that are pertinent to the nutrition care process. If data is not available or not applicable document N/A.

When background health information has been provided by another practitioner, it need not be duplicated; however, a reference to the appropriate section must be included. Information must be documented directly or referenced (i.e. noted).

4.3.1 **Client History**

Referred By: Document referral source

Diagnosis/Reason for Assessment:

Reasons for referral or assessment may include:

- consult by health care professional for nutritional assessment
- client identified through a nutrition screening process

- medical diagnosis (e.g. suboptimal growth, consider ketogenic diet).

Relevant Medical History: Document relevant medical/surgical history.

Social History: Document relevant social history, which may include:

- primary caregivers/parents separated or divorced
- foster care
- siblings
- school situation
- work schedule for caregivers/child

Activity: Check appropriate activity level or if none are appropriate add comment on blank line.

4.3.2 Biochemical Data, Medical Tests and Procedures, Medications (Relevant)

Document pertinent biochemical data, medical tests and procedures that relate to the nutrition intervention. Must be documented directly or referenced (i.e. noted).

Document pertinent medications that relate to biochemical data, medical tests and procedures (e.g. serum glucose or glycosylated hemoglobin, note antihyperglycemic agents).

Document medications with nutrition implications. Note any potential food/drug interactions.

4.3.3 Anthropometric Measurements

Anthropometric Measure	Clarification
Height and Weight	For 2-3 year olds indicate if standing height or recumbent length used. Include %iles.
HC	= head circumference
Weight/Height	For children <120 cm
IBW	Use McLaren Method (height at 50 th ile dropped vertically to 50 th ile in weight curve)
BMI	= body mass index. (kg/m ²). Include %ile
Weight History/Reason for Weight Change/Weight Velocity	Weight loss/gain over defined time periods. Document reason for weight change (e.g. poor appetite, unintentional, intentional).
Other	Other indices may be documented here such as triceps skinfold, mid arm circumference, mid arm muscle circumference

4.3.4 Nutrition-Focused Physical Findings

Check off pertinent physical symptoms with detailed information (if applicable) documented in comments/other section. If none of the physical symptoms apply, check off “no concerns”.

Examples:

Physical Symptom	Comments/Other
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✓ Appetite changes	Indicate increased/decreased
✓ Swallowing difficulty	Coughs when sips thin fluids
✓ Vomiting	Frequency
SGA Rating	Document rating level (A, B or C) with descriptor (well nourished, moderate or severe malnutrition)

4.3.5 Food/Nutrition-Related History

Check off program following child if applicable.

Food and Nutrient Intake: Check off breast milk or formula if applicable.

Composition and adequacy of food and nutrient intake (oral, enteral and/or parenteral) meal and snack patterns, current and previous diets and/or food modifications, and eating environment.

Document diet or nutrition history. May include:

- typical day intake
- food frequencies
- diet experience
- meal patterns
- eating environment
- assessment of intake compared to Eating Well with Canada's Food Guide recommendations.

Food Allergies/Intolerances: Confirm and list food allergies and/or intolerances based on information from client. State food and reaction(s).

Vitamins/Minerals/ Supplement Use: Document all vitamins, minerals and herbal supplements including complementary medicine products used.

Knowledge/Beliefs/Attitude: Understanding of nutrition-related concepts and conviction of the truth and feelings/emotions toward some nutrition-related statement or phenomenon along with readiness to change nutrition-related behaviors. May include:

- area(s) and level of food and nutrition knowledge
- beliefs and attitudes about food and nutrition
 - conflict with personal/family value system
 - distorted body image
 - motivation
 - preoccupation with food
 - preoccupation with weight
 - readiness to change nutrition-related behaviors
 - self-efficacy
 - self-talk/cognitions
 - unrealistic nutrition related goals
 - unscientific beliefs/attitudes.

Factors Affecting Access to Food: Factors that affect intake and availability of a sufficient quantity of safe, healthful food as well as food/nutrition-related supplies.

May include:

- food/nutrition program participation

- safe food/meal availability.

Behavior: Activities and actions which influence achievement of nutrition related goals. May include:

- adherence
- avoidance
- bingeing and purging
- social network/supports

Physical Activity and Function:

- type and frequency of physical activity performed on a weekly basis; include duration and intensity
- TV/screen time
- sedentary activity time
- ability to perform physical activities

4.4 NUTRITION ASSESSMENT

This section of the form documents the interpretation of the data elements that are identified on page one. These data elements are compared to criteria, relevant norms and standards to determine nutrition assessment and nutrition diagnosis. Summarize key factors which define nutrition concern(s).

Daily Energy Requirements: These requirements may be estimated using predictive equations. Indicate basis of determination.

Daily Protein Requirements: Estimated requirements in grams protein/day.

Calculated Fluid Requirements: Estimated fluid requirement using Holliday-Segar equation.

Clinical Impression: Summarize impression from data collected.

4.5 NUTRITION DIAGNOSIS

The client health record must include: the nutrition problem/diagnosis using standardized nutrition language. If no current nutrition problem identified, this should be stated. The nutrition problem/diagnosis should be documented in a PES (problem, etiology, signs & symptoms) statement.

4.6 NUTRITION INTERVENTION

Nutrition Prescription (Basic Plan): The client's individualized recommended dietary intake of energy and/or selected foods or nutrients based on current reference standards and dietary guidelines and client's health condition and nutrition diagnosis (e.g. recommended diet).

Goals/Intervention:

- document specific treatment goal(s) in relation to each intervention
- determine client-focused expected outcomes for each nutrition diagnosis. The expected outcomes are the desired change(s) to be achieved over time as a result of nutrition intervention.
- examples include: nutrient goals, education goals, anthropometric goals, medication goals, laboratory values, etc.

Nutrition Education: Indicate whether initial/brief or comprehensive.

Initial/Brief: Instruction or training intended to build or reinforce basic nutrition-related knowledge or to provide essential nutrition-related information until client returns.

Comprehensive: Instruction or training intended to lead to in-depth nutrition-related knowledge and/or skills in given topics.

Comments: Can include stage of readiness for change.

Resources Provided: Document the names of any education resources provided to the client.

Nutrition Counseling: A supportive process, characterized by a collaborative counselor-patient/resident relationship, to set priorities, establish goals, and create individualized action plans that acknowledge and foster responsibility for self-care to treat an existing condition and promote health. Document strategies used in intervention session. Strategies may include:

Motivational Interviewing: A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Goal Setting: A collaborative activity between the client and the practitioner in which the client decides from all potential activity recommendations what changes he/she will expend effort to implement.

Self-Monitoring: A technique that involves keeping a detailed record of behaviors that influence diet and/or weight.

Problem solving: Techniques that are taught to assist clients in identifying barriers to achieving goals, identifying and implementing solutions and evaluating the effectiveness of the solutions.

Social Support: Increased availability of social support for dietary behavior change. Social support may be generated among an individual's family, church, school, co-workers, health club or community.

Stress Management: Reaction to stress can cause some clients to lose their appetite and others to overeat. Management of stressful situations that may result in inappropriate eating behaviors.

Stimulus Control: Identifying and modifying social or environmental cues or triggers to act, which encourage undesirable behaviors relevant to diet and exercise. Attention is given to reinforcement and rewards.

Cognitive Restructuring: Techniques used to increase client awareness of their perceptions of themselves and their beliefs related to diet, weight and weight loss expectations.

Relapse Prevention: Techniques used to help clients prepare to address high-risk situations for relapse with appropriate strategies and thinking. Incorporates both cognitive and behavioral strategies to enhance long-term behavior change outcomes.

Rewards/Contingency Management: A systematic process by which behaviors can be changed through the use of rewards for specific actions. Rewards may be derived from the client or the provider.

Coordination of Nutrition Care: Document referrals to other health providers and community agencies/programs. Check off agencies/programs where applicable.

Referral to Community Agencies/Programs: If letter sent to EIA for special diets, document and attach copy to health record.

4.7 **MONITORING AND EVALUATION**

Indicate whether follow up will occur and date for follow up if it is booked. Determine and document follow up plan and outcomes to be monitored. Examples include:

- food and nutrient intake, knowledge, beliefs and attitudes.
- biochemical data
- anthropometric measurement outcomes
- nutrition-focused physical finding outcomes.

5.0 **SIGNATURE AND DATE:**

All chart notes are to be signed by the registered dietitian. All dietetic intern notes need to be co-signed by the RD preceptor. Graduate RD should be written if the dietitian has not successfully completed the Dietitians of Canada exam.

6.0 **PROCESSING:**

6.1 Page 1+2 of the form to be faxed or copy mailed to the referring health care provider. The original to be placed into the medical record. Dietitian may keep copy for client questions when medical record not available.

7.0 **REFERENCES:** (includes cross-references)

- 7.1 College of Dietitians of Manitoba. Professional Practice Guideline 16.0, For Health Records: Charting and Records Retention 16.6. Approved June 18, 2008.
<http://www.manitobadietitians.ca/guidelines.aspx> Accessed August 10, 2009.
- 7.2 International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process, 2nd Ed. American Dietetic Association; 2009.
- 7.3 American Dietetic Association. Nutrition care process and model part II: using the international dietetics and nutrition terminology to document the nutrition care process. J Am Diet Assoc 2008; 108(8): 1287-93.
- 7.4 American Dietetic Association. Nutrition care process and model part I: the 2008

update. J Am Diet Assoc 2008; 108(7): 1113-7.

- 7.5 American Dietetic Association. Nutrition Care Process Model. J Am Diet Assoc 2003; 103(8): 1064-1068.