Chapter 11

OVERVIEW OF NUTRITION
DIAGNOSIS AND INTERVENTION
Objectives

- Learn and describe the steps and rationale of the Nutrition Care Process
- Define and create PES statements
- Explain the important components of sound medical documentation
- Define SOAP note
- Define and create a medical note using ADIME
- Explain HIPAA
Nutrition Care

- Physicians
- RDs
- Nurses
- Pharmacists
- Physical therapists
- Occupational therapists
- Social workers
The Nutrition Care Process (NCP)

- Established by the American Dietetic Association (now the Academy of Nutrition and Dietetics) as a standardized process for the provision of nutrition care

- The patient is the central focus

- Four steps in the NCP: nutrition assessment, nutrition diagnosis, nutrition intervention, monitoring and evaluation
  1. Nutrition Assessment
  2. Nutrition Diagnosis
  3. Nutrition Intervention
  4. Monitor and Evaluate
Nutrition Screening and Assessment

- Nutrition screening is a process that identifies those who would benefit from a full nutrition assessment (for example, during patient admissions).
- Screening should be quick, simple, and easy to administer for example, the Malnutrition Screening Tool.
- Rescreen at regular intervals during hospitalization.
- Assessment occurs when screening has identified a patient at risk.
NCP- Step 1
Nutrition Screening and Assessment

Malnutrition Screening Tool

- BMI Score
  - BMI >20-0 (<30 obese) = 0
  - BMI 18.5-20-0 = 1
  - BMI <18.5 = 2

- Weight Loss Score (unplanned wt loss in 3-6 mo)
  - Wt loss <5% = 0
  - Wt loss 5-10% = 1
  - Wt loss >10% = 2

- Acute Disease Effect Score
  - Add a score of 2 if there has been or is likely to be no nutritional intake for >5 days

Add all scores

Overall Risk of Malnutrition and Management Guidelines

0 - Low risk
  - Routine clinical care
  - Repeat screening
    - Hospital - weekly
    - Care homes - monthly
    - Community - annually for special groups (e.g., those >75 y)

1 - Medium risk
  - Observe
  - Document dietary intake for 3 days if subject in hospital or care home
  - If improved or adequate intake, little clinical concern: if no improvement, clinical concern - follow local policy
  - Repeat screening
    - Hospital - weekly
    - Care home - at least monthly
    - Community - at least every

2 or more - High risk
  - Treat*
  - Refer to dietitian, nutrition support team or implement local policy
  - Improve and increase overall nutritional intake
  - Monitor and review care plan
    - Hospital - weekly
    - Care home - monthly
    - Community - monthly
  - Unless detrimental or no benefit is expected from nutritional support, e.g., imminent death

Record malnutrition risk category, presence of obesity and/or need for special diets and follow local policy. Reassess those identified at risk as they move through care settings. In the obese, underlying acute conditions are generally controlled before the treatment of obesity. If unable to obtain height and weight, alternative measurements and subjective criteria are provided (Elia, 2003).

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NCP- Step 1
Nutrition Screening and Assessment

Assessment

Comprehensive evaluation carried out by the RD using medical, health, social, nutritional and medical hx; physical examination, anthropometric data and lab values

- For individuals:
  - Patient/client through interview
  - Observation and measurements
  - Medical records
  - Referring health care provider

- For population groups:
  - Data from surveys
  - Administrative data sets
  - Epidemiological or research studies
NCP- Step 2
Nutrition Diagnosis

- Identify, prioritize, and document problems in medical record
  - Patients with a nutrition diagnosis may be at increased risk for:
    - Morbidity
    - Longer hospital stays
    - Infection
    - Complications

- Many facilities use a standardized format to document the information gathered at the nutrition assessment, and diagnosis.
A nutrition diagnosis includes documentation of the **Problem**, **Etiology**, and **Symptoms** (PES) in a clear and simple statement.

**Examples**

- Excessive CHO intake related to *evening visits to Coldstone Creamery* as evidenced by diet hx and high hs blood glucose
- Increased energy expenditure related to *multiple trauma* as evidenced by *result of indirect calorimetry*
- Altered gastrointestinal function related to *cirrhosis of the liver* as evidenced by steatorrhea and growth failure
- Excessive energy intake related to *lack of access to healthy food choices (restaurant eating)* as evidenced by diet history and BMI of 35.
- Inappropriate food choices related to *history of anorexia nervosa and self-limiting behavior* as evidenced by diet history and weight loss of 5 lb
NCP- Step 2
Nutrition Diagnosis- PES Exercise
Now you have established what is wrong - how are you fix it? (how will you intervene?)

Two steps

1. Planning: Involves the RD and the patient to set patient-centered goals.
2. Implementation: Nutrition interventions (counselling, nutrition therapy)

- Should address each problem in assessment
- Change plan as patient’s condition changes
- Interventions should be specific, what, where, when and how
Examples of Special Diets

- Calorie Control Diets
- Calorie Enhanced Diets
- Cardiac Diet
- Diabetes and Hypoglycemia Diets
- Dysphagia and Texture Alterations Diets
- Food Allergy or Intolerance Diets
- Upper GI Disorder Diets
- Lower GI Disorder Diets
- Protein Restriction Diets
- Purine-restricted Diet
- Renal Diets
NCP- Step 4
Nutrition Monitoring and Evaluation

- Goal is to meet nutritional needs of patient
- Have the goals been met? For example has the patient been able to lower her fasting her blood glucose?
- If not, must establish new interventions that WILL work.
The Nutrition Care Process (NCP)

The Nutrition Care Process and Model

Screening & Referral System:
- Identify risk factors
- Use appropriate tools and methods
- Involve interdisciplinary collaboration

Practice Settings

Nutrition Assessment & Re-assessment:
- Obtain/collect timely & appropriate data
- Analyze/interpret with evidence-based standards
- Document

Nutrition Diagnosis:
- Identify & label problem
- Determine cause/ contributing risk factors
- Cluster signs & symptoms/ defining characteristics
- Document

Nutrition Intervention:
- Plan nutrition intervention
- Formulate goals & determine a plan of action
- Implement nutrition intervention
- Care is delivered & actions are carried out
- Document

Nutrition Monitoring & Evaluation:
- Monitor progress
- Measure outcome indicators
- Evaluate outcomes
- Document

Social Systems

Outcomes Management System:
- Monitor the success of the Nutrition Care Process implementation
- Evaluate the impact with aggregate data
- Identify and analyze causes of less than optimal performance and outcomes
- Refine the use of the Nutrition Care Process

Evidence-based practice is using all available scientific data on which to base your interventions.

Can’t recommend a diet or plan because you “feel”

In the 90s the ADA began developing nutrition practice guidelines and evaluation how their use affected outcomes. The first was in DM management.

This type of care is called MNT and using “best practices” ensures the best outcome for the patient and means your more likely to receive insurance reimbursement.
Medical records are legal documents - if something is not recorded it never happened

- Why record?
  - Ensures that your nutrition diagnosis will be relevant, thorough and effective - the RD identified the problem and the solution
  - Allows the entire health team to understand the rationale for care and will more likely to be followed

2014- Records must be electronic: Electronic Health Record (EHR), Electronic Medical Record (EMR), Personal Health Record (PHR) PHR is patient-facing

- Documents patient care
- Stores and manages lab results
- Communicate through departments and offices
In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA)- designed to ensure that health insurance eligibility was maintained when people lost or changed jobs.

- Patients must be notified if their Protected Health Information (PHI) is shared outside the healthcare setting.
- NEVER look at a patient’s chart unless he or she is under your direct care.
Entries into the medical record can take different forms, when it comes to nutrition it’s the SOAP note (old), or the ADIME format (new)

Notes should be:
- Concise
- Informative
- Black pen or typed (legible if written)
- Include date, time, and service
- Entries should be in chronological order
- Grammar and spelling important
- MUST be signed with credentials
- No opinion
- Done in real-time
- Late entries need to be documented as such
- If you need to correct it must be documented as a correction (White-out not allowed on paper charts)
- If you need to add information must insert addendum
SOAP (Subjective, Objective, Assessment, Plan)

Subjective
- Tolerance of current diet
- Reports of weight loss of appetite decrease
- Diet hx information

Objective
- Ht, wt, UBW, %UBW
- Relevant lab values
- EER

Assessment
- Appropriateness of current diet documented
- Interpretation of abnormal lab values
- Comments on diet hx
- Rational for change in diet (prn)

Plan
- Monitor I/O
- Request more labs (prn)
- Plan for f/u care
- Encourage PO

SIGN NOTE______________________
Documentation in the Nutrition Care Record-SOAP

- **S:** Patient works night shift, eats two meals a day, before and after his shift; fried foods, burgers, ice cream, beers in restaurants. Does not add salt to foods. Activity: Plays golf 1x month.

- **O:** 34 y.o. male s/p MI with history of htn, DM2, hyperlipidemia.  
  - Ht: 5 ft. 10 in; wt: 250 lb; BMI 36, Obesity II

- **A:** Excessive sodium intake related to frequent use of vending foods as evidenced by diet history. Pt could benefit from increased activity and gradual wt loss as recovery allows

- **P:** Provided basic education on 3-4 gram sodium diet and wt management guidelines  
  - Patient will return to outpatient nutrition clinic for lifestyle intervention and counseling
ADIME developed to facilitate the NCP

- A – Assessment
- D – Diagnosis
- I – Intervention
- M – Monitoring
- E - Evaluation
Assessment

- All data pertinent to clinical decision making, including diet history, medical history, medications, physical assessment, lab values, current diet order, estimated nutritional needs
- Should include relevant data only
Diagnosis

- Should include PES statement for nutrition diagnosis
- Patients may have more than one diagnosis, but try to choose the one or two most pertinent, or the ones you mean to address
Intervention

- What do you recommend or plan to do to address the nutrition diagnoses?
  - Recommend change in food-nutrient delivery (supplement, change in diet, nutrition support, vitamin-mineral supplement)
  - Nutrition education
  - Nutrition counseling
  - Coordination of nutrition care
Monitoring and Evaluation (ME)

- What will you monitor to determine if the nutrition intervention was successful?
- Generally based on the signs and symptoms
  - Weight
  - Intake
  - Lab values
  - Clinical symptoms
A - 34 y.o. male s/p MI with history of htn, DM2, hyperlipidemia; ht: 5 ft. 10 in; wt: 250 lb; BMI 36, obesity II. Patient works night shift, eats two meals a day, before and after his shift: fried foods, burgers, ice cream, beer - dines in restaurants. Does not add salt to foods. Activity: Plays golf 1x month.

D - Excessive energy intake and excessive sodium intake related to frequent use of restaurant foods as evidenced by diet history.

I – Provided basic education on 3-4 gram sodium diet and wt. management guidelines (nutrition education); pt to return to outpatient nutrition clinic for lifestyle intervention.

ME – Evaluate weight, blood pressure, diet history at outpatient visit sodium intake, energy intake; fat intake. Re-check lipids in 3 months.
MJ is a 75 y.o. African-American female with PMH of HTN and DM admitted with cellulitis of right foot. She is retired and active in her church. She does not get around much due to arthritis in her knees. Follows no special diet at home; eats breakfast at Bob Evans daily; biscuits and sausage gravy, eggs, and grits.

“The doctor said I had a little sugar; I don’t eat much bakery.”

Does not test glucose at home

Ht: 5 ft. 3 in; weight 184 lb. BMI 32.6;

Meds: Toprol 20 mg b.i.d.; no meds for diabetes at present

Labs: TC: 250; LDL-C: 180 mg/dl; A1C: 9%;