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 patient/resident 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. Otherwise it should be directed at reducing the 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 patient/resident 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 patient/resident is a new admission or new consult/referral. Check off reassessment for the following: LTC annual review, scheduled review, or complete nutrition assessment required due to change in status.

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**

**Relevant Medical History:** Document medical diagnosis and relevant medical/surgical history.

**Social History/Cognitive Function:** Check off pertinent social history or cognitive function with detailed information (if applicable) documented in comments/other section.

Example:

<table>
<thead>
<tr>
<th>Cognition</th>
<th>Comments/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Confused</td>
<td>Meal set up and direction at meals needed</td>
</tr>
</tbody>
</table>

**Other comments:** may include: various meal time behaviours such as distracted at meals.
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 anti-hyperglycemic agents).

Document medications with nutrition implications. Note pertinent food and drug interactions.

4.3.3 **Anthropometric Measurements**

<table>
<thead>
<tr>
<th>Anthropometric Measure</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height and Weight</td>
<td>Identify if source of information is actual (measured), reported by patient/resident or relative, or estimated.</td>
</tr>
<tr>
<td>BMI</td>
<td>= body mass index. (kg/m²)</td>
</tr>
<tr>
<td>Comparative Standard Weight Range</td>
<td>Indicate method for determining reference standard, i.e. normal range BMI, weight for age, BMI for age, etc.</td>
</tr>
<tr>
<td>Weight History/Reason for Weight Change</td>
<td>Weight loss/gain over defined time periods. Document reason for weight change (e.g. poor appetite, unintentional, intentional).</td>
</tr>
<tr>
<td>Other</td>
<td>Other indices may be documented here such as waist circumference, hip circumference, waist/hip calculations.</td>
</tr>
<tr>
<td>Significant Weight Change</td>
<td>Identify if significant weight change is evident. Check off appropriate parameter.</td>
</tr>
</tbody>
</table>

4.3.4 **Nutrition-Focused Physical Findings**

Check off pertinent physical symptoms with detailed information (if applicable) documented in space below finding. If none of the physical symptoms apply, check off “no concerns”.

Examples:

<table>
<thead>
<tr>
<th>Physical Symptom</th>
<th>Comments/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Appetite changes</td>
<td>Indicate increased/decreased</td>
</tr>
<tr>
<td>✓ Swallowing difficulty</td>
<td>Coughs when sips thin fluids</td>
</tr>
<tr>
<td>✓ Impaired skin integrity</td>
<td>Stage of ulcer</td>
</tr>
<tr>
<td>✓ Vomiting</td>
<td>Frequency</td>
</tr>
<tr>
<td>SGA Rating</td>
<td>Document rating level (A, B, or C) with descriptor (well nourished, moderate or severe malnutrition)</td>
</tr>
</tbody>
</table>

4.3.5 **Food/Nutrition-Related History**
**Food Allergies/Intolerances:** Confirm and list food allergies and/or intolerances based on information from patient/resident. State food and reaction(s).

**Diet Order:** Current diet order(s), as per health record, includes oral diet, NPO, or tube feeds. Previous, relevant diet orders may be noted.

**Food & Nutrient Intake:** 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. Include source of information (resident, family or other).

Examples:
- description of food and drink regularly provided and consumed
- enteral and/or parenteral nutrition intake
- macro and micronutrient intake.

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 Food Guide recommendations.

**Vitamins/Minerals/Herbal 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
- end of life decisions.

**Behaviour and Physical Function:** Activities and actions which influence achievement of nutrition-related goals. Physical activity, cognitive and physical ability to engage in self-feeding. May include:
- meal duration
- percent of meal time spent eating
- preference to drink rather than eat
- refusal to eat/chew
- rumination
- fatigue during eating process resulting in inadequate intake
- rigid sensory preferences
- physical/cognitive ability to self-feed
- ability to position self in relation to plate
- receives assistance with intake
- ability to use adaptive eating devices.
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 requirement in grams protein/day.

Other: May include specific vitamin, mineral, or fluid requirements or other macronutrient goals.

4.5 NUTRITION DIAGNOSIS

The patient/resident 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 and symptoms) statement.

4.6 NUTRITION INTERVENTION

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

Goals/Intervention:
- document specific treatment goal(s) in relation to each intervention.
- determine patient/resident-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.
- educate/Counsel on nutrition related issues as required
  - Nutrition Education: A formal process to instruct or train a patient/resident in a skill or to impact knowledge to help patients/residents
  - 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.

4.7 MONITORING AND EVALUATION

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 findings outcomes.

*Nutrition Risk Determination:* The purpose of nutrition risk assignment is to determine each patient/resident’s level of nutrition risk, to facilitate prioritization of workload and establish frequency of follow up for each patient/resident. Circle pertinent findings and determine nutrition risk and frequency of follow up.

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


