Entity Name & Region: Clinical Nutrition Service-WR	
Subject: Clinical Dietitian Record Content & Electronic Documentation Standards: Nutrition Care Process	
Original Date: Version 1 August 2010	**Effective:** August 2012
Reference: 028010-03 Version-7	**Replaces Number:** DPP NUT-01-01-03
Targeted Employees/Departments: Clinical Dietitians	

1. Purpose:

1.1 To establish a well-defined policy and procedure regarding the Clinical Dietitian record content and documentation standards with respect to patients' medical records.
1.2 To provide standards on when to conduct routine Nutrition Care Process.

2. Definitions:

2.1 Nutrition Care Process (NCP): is a systematic problem solving method that dietetic professionals use to critically think and make decisions to address nutrition related problems and to provide safe and effective quality nutrition care.

2.2 Nutrition Assessment: is the systematic process of obtaining, verifying and interpreting data (laboratory results, anthropometric, physical, and dietary) in order to make decisions about the nature and cause of nutrition-related problems. Nutrition assessment is used to determine priorities of nutritional management.

2.3 Nutrition Diagnosis: involves the identification and labeling that describes an actual occurrence of a risk of or potential for developing nutritional problems that qualified dietetic professionals are able to treat independently. A nutrition diagnosis provides a link to setting realistic and measurable goals, identifying expected outcomes, selecting appropriate interventions and tracking progress towards attaining those expected outcomes.

2.4 Nutrition Interventions: are purposefully planned actions to change a nutrition related behavior or risk factor. It involves selecting, planning and implementing appropriate actions to meet the patient's nutrition needs and is driven by the nutrition diagnosis. It provides the basis upon which outcomes are measured and evaluated.
2.5 Nutrition Monitoring and Evaluation:

2.5.1 Monitoring refers to the review and measurement of a patient's status at pre-planned follow-up points with regards to the nutrition diagnosis, and intervention goals and outcomes.

2.5.2 Evaluation is the systematic comparison of current findings with previous status intervention goals or a reference standard.

2.5.3. The purpose of monitoring and evaluation is to determine the degree to which progress is made and goals or desired outcomes of nutrition care are met with previous status intervention goals or a reference standard. The purpose of monitoring and evaluation is to determine the degree to which progress is made and goals or desired outcomes of nutrition care are met.

2.6 Nutrition Screening: is an interdisciplinary process and involves gathering pre-established data from the medical record, computer, or by brief patient interview. The collected data is then evaluated to determine if the patient is nutritionally compromised or at risk for malnutrition, and is based on the criteria developed by the dietitian and the interdisciplinary care team.

2.7 Nutrition Education: the nutrition education process utilizes instruction or counseling to bring about desirable changes in behavior, attitudes, environmental influences, and understanding of food. Such desirable changes lead to food and nutrition practices which are scientifically sound, practicable and consistent while meeting individual needs with available food resources.

2.8 QuadraMed Computerized Patient Record (QCPR): is a collection of NCP information entered into the system by, or accepted by the Clinical Dietitian and stored electronically.

2.9 Clinical Dietitian Record: describes the Clinical Dietitian record in the electronic system QCPR and includes confidential health and dietary information about a patient, maintained for the purpose of registration, treatment and decision-making.

2.10 Documentation: for the purpose of this DPP refers to NCP Format of documentation by the Clinical Dietitian is recorded in a patient's medical record.

2.11 Incomplete Clinical Dietitian Record: refers to a record that is considered incomplete when the Clinical Dietitian documentation is not conformance with the guidelines as set forth in and completed NCP.

2.12. KAMC-J: refer to King Abdulaziz Medical City-Jeddah

3. Policy Statements:

3.1 Clinical Dietitians are responsible for completing their respective electronic documentation for patients under their care within twenty-four (24) hours (hrs) of admission.

3.2 The patient's record will contain sufficient information to critically think and make decisions to address nutrition related problems and to provide safe and effective quality nutrition care.

3.3. The patient's record and all its content may be used as legal evidence.

3.4. Nutrition Care will be provided through the NCP for in-patients and outpatients identified at nutrition risk.

3.5. Electronic Clinical Dietitian Documentation:

3.5.1. Demonstrates the Clinical Dietitians' accountability and records their professional practice.

3.5.2. Must be clear, concise, complete, and patient-centered and confidential. The must avoid personal judgments about individuals; however, professional opinions may be documented as such.

3.5.3. Must record the actions taken by the Clinical Dietitian for addressing the patient's needs as well as their response to the actions taken.

3.5.4. Will be used in the evaluation of the performance of the Clinical Dietitian for performance appraisal.

3.6. Abbreviations:

3.6.1. The abbreviations, acronyms and symbols listed within the "Do Not Use List" must apply for Electronic Clinical Dietitian documentations:

3.6.1.1 Clinical Dietitian must be aware of all prohibited abbreviations and ensure that these abbreviations are not used.

3.6.1.2 A list of prohibited abbreviations is available and maintained on the Intranet Homepage, and is reviewed, updated and ratified by the Corporate Pharmacy & Therapeutics Committee.

3.6.1.3 Abbreviations, acronyms and symbols that are permitted for use within clinical documentation.

4. Procedures:

4.1 Electronic Clinical Dietitian Documentation:

4.1.1 The Clinical Dietitian will follow the latest NCP format of the American Dietetic Association:

4.1.1.1 Nutritional Assessment.

4.1.1.2 Nutritional Diagnosis.

4.1.1.3 Nutritional Intervention.

4.1.1.4 Nutritional Monitoring and Evaluation.

4.1.2 All Clinical Dietitians will document relevant information regarding patient's adherence to the prescribed diet via the electronic QCPR system.

4.1.3 Generation and Content:

4.1.3.1 Entries will not be made in advance.

4.1.3.2 Pre-dating or back-dating an entry is prohibited.

4.1.3.3 The system will not allow data entry that is back-dated.

4.1.3.4 The system will not allow an entry for a patient unless the patient has an active encounter with the hospital.

4.1.3.5 The system will not allow orders for a procedure for an inpatient unless the patient is present in a ward/unit.

4.1.4 Modification and Correction:

4.1.4.1 The system does not permit any entered and accepted documentation to be deleted.

4.1.4.2 The system will allow modification to saved documentation either as a correction to previously accepted data, or as an addendum.

4.1.4.3 Any correction made in documentation will be highlighted and indicated by the system as being corrected. The reason for correction and the responsible Clinical Dietitian can be traced.

4.1.5. Privacy and Security:

4.1.5.1 Before a Clinical Dietitian is granted access to the electronic system, a request form must be submitted to the Clinical Information Management Systems (CIMS) department indicating the following:

4.1.5.1.1 Clinical Dietitian's Name.

4.1.5.1.2 Clinical Dietitian's Badge number.

4.1.5.1.3 Clinical Dietitian's Pager.

4.1.5.1.4 Clinical Dietitian's Department.

4.1.5.1.5 Clinical Dietitian's Position.

4.1.5.1.6 Clinical Dietitian's Signature.

4.1.5.1.7 Chief Clinical Nutrition Services' Signature.

4.1.5.2 The CIMS department will assign a unique user Identification (ID) for each Clinical Dietitian. This ID will be associated with and enable the tracking of the user identity on the system.

4.1.6 Password Management:

4.1.6.1 The system will automatically generate a random password upon creating an account. This will be provided to the user and he/she will be informed to change the password upon the first login to the system.

4.1.6.2 The system will not accept a password less than six (6) characters in length.

4.1.6.3 The system will prompt for a password change every six (6) months. Otherwise, the password will expire and the user will not be able to login on the system. He/she will need to request reactivation of the account.

4.1.6.4 Each Clinical Dietitian will be informed that his/her password must **not** be shared, written down or stored in locations where it can be found and to be changed immediately if compromised.

4.1.7 Access Control:

4.1.7.1 The Clinical Dietitian will be informed of the importance of logging off after completing data entries or reviewing the patient's Health Record, and will be made aware of subsequent security threats that may occur from access abuse.

4.1.7.2 The system will be configured to terminate a logon session after a predetermined time of inactivity (automatic logoff after fifteen (15) minutes of inactivity).

4.1.8 Audit Control: The following audit log will be captured on the system:

4.1.8.1 Clinical Dietitian’s access and account activity.

4.1.8.2 Clinical Dietitian’s dormant account reports.

4.1.8.3 Clinical Dietitian’s failed login reports.

4.1.8.4 Clinical Dietitian’s attempts to guess passwords.

4.1.8.5 Clinical Dietitian’s changes to user privileges.

4.1.9 Clinical Dietitian Endorsement:

4.1.9.1 For continuity of care, information about the patient's NCP is handed over among Clinical Dietitians during transfers between units using appropriate forms. Information documented includes:

4.1.9.1.1 The reason for admission

4.1.9.1.2 Significant findings

4.1.9.1.3 Diagnosis made

4.1.9.1.4 Any procedures performed

4.1.9.1.5 The patient's condition on transfer

4.1.9.1.6 The patient's progress

4.1.9.1.7 The reason for the transfer

4.1.10 Telephone & Verbal Orders/Discussions:

4.1.10.1 All telephone or verbal orders and relevant discussions must be documented in the patients' medical record.

5. Equipment/Forms:

5.1 Computer for Electronic Documentation (QCPR).

5.2 Patient Medical History.

5.3. Initial Nutrition Assessment Form.

6. Related Reference:

6.1 American Dietetic Association www.eatright.org

6.2 American Dietetic Association Nutrition Care Process.

6.3 American Dietetic Association Evidence Based Guides for Practice.

6.4 Initial Nutrition Assessment Form.

7. Appendices:

None

8. Recommendations:

None