

NCP-SP Workshop

Nutrition Care Process and Writing PES

Annalynn Skipper, Sherrie Jones

Objectives

- Provide Overview of Nutrition Care Process & Model
- Apply Nutrition Diagnoses terms and creating PES statements to five cases submitted
- Apply Nutrition Intervention terms to five cases
- Apply Nutrition Monitoring and Evaluation Terms

Learning Need Codes to choose from

3000 Nutrition Assessment and Diagnosis

3005 Nutrition Diagnosis

6010 Behavior Change Theories, techniques

5390 Care planning, Documentation and Evaluation

5070 Pediatric (20 min only)

5100 Elderly (20 min only)

5440 Enteral and parenteral nutrition (20 min)

5340 Renal (20 min)

5430 – End of life care (If last case is covered)

Schedule:

- Introductions & Overview of Questions and Answers – Approach to Webinar *10 min*)- *Annalynn Skipper and Esther Myers*
- In-depth Discussion of each Step in NCP (25 cases (*1 1/2 hour*)-(ideally 20 minutes per case)
 - Case #1 – 75 year old frail elderly – Sherri Jones*
 - Case #2- Pediatric – Annalynn Skipper*
 - Case #3-Home enteral nutrition with reassessment – Annalynn Skipper*
 - Case #4- Renal Dialysis – Sherri Jones*
 - Case #5- End of Life – Annalynn Skipper*

For each case be prepared to answer the following questions. There will be polling questions for each case

- What is the most important nutrition assessment data to selecting a nutrition diagnosis
 - What additional information would you need to make a nutrition Dx / PES statement?
 - Which of the following Nutrition Diagnosis would you select?
 - What would be the etiology?
 - What components need to be included in the Nutrition Prescription
 - What intervention would address the etiology
 - What would you select to monitor and evaluate
- Questions and Future Directions (*5 min*)
(*you will submit questions via the webinar*)

Welcome! NCP-SL Follow-up Webinar

Be Sure to have downloaded handouts from
ADA Website and publication available for
Webinar
February 2008



© 2006 American Dietetic Association (ADA)

THANK YOU!!

- We received over 30 cases from the Teleseminar and selected five to represent various areas of practice and demonstrate common questions
- We also created a FAQ of questions received after the Webinar and it is included in the handout.

© 2006 American Dietetic Association (ADA)

Objectives

- Provide Overview of Nutrition Care Process & Model
- Apply Nutrition Diagnoses terms and creating PES statements to five cases submitted
- Apply Nutrition Intervention terms to five cases
- Apply Nutrition Monitoring and Evaluation Terms

© 2006 American Dietetic Association (ADA)

Learning Need Codes to choose from

- 3000 Nutrition Assessment and Diagnosis
- 3005 Nutrition Diagnosis
- 6010 Behavior Change Theories, techniques
- 5390 Care planning, Documentation and Evaluation
- 5070 Pediatric (20 min only)
- 5100 Elderly (20 min only)
- 5440 Enteral and parenteral nutrition (20 min)
- 5340 Renal (20 min)
- 5430 – End of life care (If last case is covered)

© 2006 American Dietetic Association (ADA)

Today's Webinar

- Introductions & Overview of Questions and Answers – Approach to Webinar *10 min*- *Esther Myers*
- In-depth Discussion of each Step in NCP (25 cases *(11/2 hour)-(ideally 20 minutes per case)*)
 - Case #1 – 75 year old frail elderly – *Sherri Jones*
 - Case #2- Pediatric – *Annalynn Skipper*
 - Case #3-Home enteral nutrition with reassessment – *Annalynn Skipper*
 - Case #4- Renal Dialysis – *Sherri Jones*
 - Case #5- End of Life – *Annalynn Skipper*
- Questions and Answers

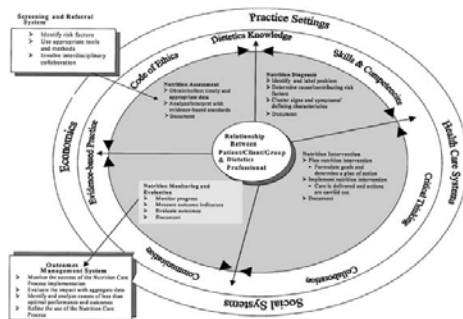
© 2006 American Dietetic Association (ADA)

Common Questions

- How does NCP-SL related to state/federal regulations?
- Is it necessary to have Nutrition Dx (Potential?)
- Do we use Domains and term or just terms?
- How does this interface with E H Rs?
- What does Re-Assessment look like?
- How does this work in dialysis
- What about the DTR?

© 2006 American Dietetic Association (ADA)

The Nutrition Care Process & Model



© 2006 American Dietetic Association (ADA)

Nutrition Care Process

Nutrition Assessment

- Obtain adequate information in order to identify nutrition-related problems
- Systematic process of obtaining, verifying and interpreting the data in order to make decisions about the nature and cause of nutrition related problems
- Re-assessment at subsequent visits includes evaluating Monitoring and Evaluation parameters
- Includes combined list of NA and M&E terms
 - 10 Domains with 59 terms
 - Knowledge & Behavior, Access, Physical Activity & Function, Intake, Anthropometrics, Biochemical, Physical Exam, Client History, Comparative Standards

© 2006 American Dietetic Association (ADA)

Nutrition Care Process

Nutrition Diagnosis

- Identification and labeling of a nutrition problem
 - Three Domains of Nutrition Diagnoses
 - Over 60 individual Nutrition Diagnoses Terms
- Articulated as PES Statement
 - Problem
 - Etiology
 - Signs and Symptoms

© 2006 American Dietetic Association (ADA)

Nutrition diagnosis step is articulated in PES Statement

PES Statement =

Problem...

related to... **E**tiology...

as evidenced by... **S**igns or symptoms

© 2006 American Dietetic Association (ADA)

Evaluating your PES Statement

- There are no "right" or "wrong" PES statements

- But

Some are better than others!!

Questions have been developed for you to use when evaluating your PES statement

© 2006 American Dietetic Association (ADA)

Evaluating your PES statement

- **P**
 - Can the RD resolve or improve the nutrition diagnosis ?
 - Consider the intake domain as the preferred problem
- **E**
 - Is the etiology the "root" cause?
 - Will RD intervention resolve the problem by addressing the etiology?
 - Can RD intervention at least lessen the signs and symptoms?
- **S**
 - Will measuring the signs and symptoms indicate if resolved or improved?
 - Are the signs and symptoms specific enough?
- **PES Overall**
 - Does nutrition assessment data support the nutrition diagnosis, etiology, and signs and symptoms?

© 2006 American Dietetic Association (ADA)

Nutrition Care Process



Nutrition Intervention

- Specific set of activities and materials used to address the nutrition problem
 - Plan the Intervention
 - Prioritize Nutrition Diagnoses
 - Consult evidence based guides
 - Jointly determine patient-focused expected outcomes
 - Develop Nutrition Prescription
 - Implement the Nutrition Intervention
 - Four Domains of interventions
 - Food and/or Nutrient Delivery, Nutrition Education, Nutrition Counseling, Coordination of Nutrition Care
 - Over 60 nutrition intervention terms

© 2006 American Dietetic Association (ADA)

Nutrition Care Process



Nutrition Monitoring and Evaluation

- Determine degree to which progress is being made toward goals and or desired patient-focused expected outcomes
 - Monitoring - Review and measurement of the status at scheduled intervals
 - Evaluation – systematic comparison of current findings with previous status, intervention goals, and or a reference standard
- Four domains of M&E
 - Nutrition Related Behavioral/Environmental Outcomes, Food and Nutrient Intake Outcomes, Nutrition-Related Physical Symptom Outcomes; Nutrition-Related Patient-Client Centered Outcomes

© 2006 American Dietetic Association (ADA)

Each case will include polling on the following questions:

- What is the most important nutrition assessment data to selecting a nutrition diagnosis
- What additional information would you need to make a nutrition Dx / PES statement?
- Which of the following Nutrition Diagnosis would you select?
- What would be the etiology?
- What components need to be included in the Nutrition Prescription
- What intervention would address the etiology
- What would you select to monitor and evaluate

© 2006 American Dietetic Association (ADA)

Cases

© 2006 American Dietetic Association (ADA)

Questions??



© 2006 American Dietetic Association (ADA)

NCP Post Teleseminar Questions (Themes)

Consider updating the NCP FAQs on the website link

Submitted to: Esther Myers and ADA SL/NCP Committee

Submitted by: Sherri Jones and Annalynn Skipper

Date: February 6, 2008

1. In the long term care setting how does the NCP relate to the federal/state requirement of completing the MDS and RAP components, especially if the resident does not have a current nutrition problem/nutrition diagnosis?

The NCP has no impact on the MDS or RAP criteria. It provides a framework for dietitians dealing with problems identified using this system. Long term care staff use the RAP as the basis to consult a dietitian. The dietitian uses the Nutrition Care Process to complete an assessment, diagnose nutrition problems, plan and implement the intervention, and monitor the patient's response to the intervention. If the patient has no current nutrition problem or diagnosis, the dietitian should clearly state this in the medical record. The Standardized Language can be incorporated to document the steps in the nutrition care process.

2. Is it necessary to have a nutrition diagnosis for a "potential" problem? In some long term care settings, dietitians believe that they must address all potential problems.

Diagnosing "potential" problems is not recommended because there are insufficient data demonstrating that potential problems will turn into real ones. Rather than diagnose a potential problem, it is appropriate to address existing ones so that they do not cascade into additional problems. For example, the dietitian who encounters a long term care resident that does not eat well will plan and implement an intervention that increases the resident's intake. In doing this, "potential" problems such as involuntary weight loss, or inadequate fluid intake are addressed. Many dietitians in long term care facilities have developed systems to alert them of the potential for nutrition problems such as monitoring food consumption or plate waste records, hydration carts, and regular measurements of weight. Another way to think of this is to ask the following question: "If the dietitian is doing everything appropriate to optimize the resident's food and nutrients, then what potential problems are not being addressed?" If there is an alert and the RD is going to take action, then the sub-optimal or inadequate intake already exists.

3. When documenting using the SL for Interventions and Monitoring and Evaluation specifically, does one need to use both the domain and sub domain language? In other words, what is the required or preferred SL category (headings/subheadings) in nutrition documentation?

The wording with numbered codes beside it is likely the most specific. It is up to individual institutions how specific they wish to be.

4. How is the standardized language and ADIME format to be incorporated into an electronic health record?

Many institutions have incorporated the standardized language into their medical record using drop down boxes which contain the terms. Sophisticated electronic health records may incorporate the definitions of the terms so that they can be accessed by moving the cursor over the terms. Medical record vendors are working on providing packages that have this information available. In other institutions, the dietitians incorporate the standardized language in free text portions of the medical record. However if the language is used in free text it is not “data” and reports are not usually available. The ideal situation is to have the terms included as data elements that the RD can select from within the documentation section that relates to the terms. It is the correct terms and level of detail rather than a specific format that are hallmarks of high quality medical record documentation. The Nutrition Care Process Committee is working on an Electronic Health Record Toolkit that will be available this summer that will assist RDs as they implement both the NCP and SL in E H Rs.

5. Is there a fee for using the ADA SL in an electronic health record?

The answer to this question depends upon how the information is used. Please contact ADA’s Office of Scientific Affairs and Research for details. If the language is simply used in free text there is no charge, however if the institution or software company of the electronic health record imbeds the terms as data elements it now becomes part of the software and requires permission and fees. The fees are used to ensure that the requestor is provided a copy of the new terms each year with linkages from previous terms. This situation is temporary until our language is transitioned into other languages (such as SNOMED) and in that case the institution will likely already have a license for that set of terms (which now include our language).

6. How is reassessment documentation to be formatted for the NCP? Shall it still fit into the ADIME format and where do you put the original nutrition diagnostic statement(s)?

In practice, new assessment data is available on follow-up. Since this information has the potential to change the diagnosis or serves to inform the dietitian about the need to modify the diagnosis or intervention, it should be recorded in the follow-up note. Many facilities use a model of charting by exception, and would only record new information while others will repeat original data in the follow-up note to improve clarity and convenience. These decisions can be made at the facility level. There are case examples on the ADA website that provide examples of follow-up notes.

7. How does nutrition risk screening and levels of nutrition risk (low, moderate, high) relate to the NCP and the nutrition diagnosis?

Nutrition Screening is antecedent, but is outside the Nutrition Care Process. Thus it should not change the nutrition screening process. At some point, studies will be needed to identify screening criteria that correctly identify patients or clients likely to have a nutrition diagnosis, but that is in the future. The ADA is currently completing evidence analysis on the EAL that is documenting the level of evidence available to support various nutrition screening parameters. It is anticipated to be available within 12 months.

8. As a CDE who also addresses non-nutrition problems such as foot care, blood glucose monitoring, insulin administration, etc. how are these issues to be addressed in documentation of interventions and monitoring and evaluation – if there are not SL specific to these issues.

The Standardized Language is designed to describe patient nutrition problems which the dietitian is uniquely qualified to address. Of course, patients have other problems that dietitians treat, but that are not uniquely within the dietetics domain. For example, dietitians perform interventions such as teaching insulin administration and blood glucose monitoring activities, but so do nurses, pharmacists, physicians. Thus these interventions are not unique to the dietetics domain. Dietitians who perform these activities are encouraged to document them as required in the work setting using other languages or terms as appropriate.

9. How are dietitians who practice in a dialysis clinic to incorporate the NCP?

By using the Nutrition care Process as a four step problem solving method, dietitians in the dialysis clinic can assess and diagnose nutrition problems then plan and implement interventions, and monitor the results. The NCP provides a framework for this process while the standardized language provides common terms so that dietitians in all dialysis facilities can clearly communicate the details of nutrition care.

10. Are DTRs required/permitted to practice using the NCP? I understand that the revised ADA SOP only allow DTRs to collect assessment information (step 1). However the CMS standards state that a DTR cannot “assess” a patient. Will this be an issue?

The DTR Scope of Practice clearly describes the role of the DTR including what activities can be performed independently or with supervision. The proposed SOP clearly describes the activities of the DTR relative to each of the four steps of the Nutrition Care Process. The version being considered now was written with careful consideration of the CMS regulations which surveyors have interpreted as prohibiting non-dietitians from independently assessing patients. However all RDs should be aware that they are the licensed professional and that regardless of how the work is divided in their institution the DTR is practicing UNDER the RDs license with RD oversight since the RD carries the license. There are no guarantees that there will or will not be issues in individual facilities. The intent of Scope of Practice documents is to provide direction as to appropriate levels of activities for DTRs and RDs. Please see the answer on the FAQ that is posted on the ADA website (included at the end of the handout)

NCP Follow-up Webinar: Feb. 28, 2008

Case Example #1: 75 year old male

Step #1: Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Labs (1/24/08) Alb 3.4 L, Pre-alb 15.5 L (1/25/08) GFR 48 L EGD (1/29) revealed gastroparesis, swallow eval (1/30) indicates dysphagia
<i>Anthropometric Measurements</i>	Ht: 5'11" (180.3cm), Wt: 120lb. (54.5 kg), BMI 16.7underwt IBW: 172lb. (78.2 kg), 70% IBW Weight hx: 119-125lb. last 5 years, 170lb. many years ago No significant recent wt loss
<i>Physical Examination Findings</i>	Appears frail Skin intact
<i>Food/Nutrition History</i>	Pt not a "big eater" as stated by wife, tried supplements in the past – dislikes Boost, Ensure, and Mighty Shakes Diet at home – regular Pt's current appetite poor- refuses many meals. Pt's wife selects menus for him Current diet order: pureed, low fat, low residue with honey-thick liquids
<i>Client History</i>	Dx: hip fx, malnutrition. PMed Hx: severe COPD, CKD, PVD, chronic SOB, Hx of EtOH abuse- none x2 years, quit smoking in 2007 Meds hx: Megace – wife reports it helped initially but not anymore Hx of underweight last 5 years, does not eat well at home

Estimated Needs: 1600+ kcals/day (30 kcals/kg), 65+ grams protein/day (1.2 g/kg)

Step #2: Nutrition Diagnosis

1. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____
2. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____
3. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____

Case #1 continued...

Step #3: Nutrition Intervention

Nutrition Prescription: (nutrient needs + recommended diet/regimen)

Interventions: (actions &/or recommendations)

1.	_____
Goal(s)	_____
2.	_____
Goal(s)	_____
3.	_____
Goal(s)	_____
4.	_____
Goal(s)	_____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

1.	Indicator _____
	Criteria _____
2.	Indicator _____
	Criteria _____
3.	Indicator _____
	Criteria _____
4.	Indicator _____
	Criteria _____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Case Example #2: An underweight child (first encounter)

Step #1: Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Normal GI study and modified barium swallow Normal electrolytes, renal function, thyroid function tests
<i>Anthropometric Measurements</i>	Weight: 9.61 kg, < 3 rd percentile weight/age, 74% standard, z-score -3.1 2 nd percentile weight/length, 88% standard 8 th percentile BMI/age Length: 81.5 cm, < 3 rd percentile, 91 % standard
<i>Physical Examination Findings</i>	Patient presents with mild stunting and wasting by Waterlow criteria.
<i>Food/Nutrition History</i>	Full oral eater with limited variety. Takes few small bites of solids at each meal, 3x/day. Pretends to eat food by pushing it around her plate with the fork without consuming much quantity. Drinks 28 – 32 ounces per day of 1.5 kcal/ml supplement. She has lost 300g over the past 2 months. The expected weight gain for her age is 6 g/day. Although length is below the 3 rd percentile, she is following a curve parallel to the growth curve with stable z scores. Her estimated intake is 130-140 kcal/kg from supplement alone.
<i>Client History</i>	30 month old female, corrected age 26 months. History of premature birth at 25 weeks gestation; severe BPD; poor weight gain despite high calorie intake. GI: Constipation and withholding stools, relieved with prune juice. Emesis 1 x/day associated with bedtime crying episodes, improving with behavior modification. Meds include Flovent and Combivent which may cause vomiting and constipation.

Step #2: Nutrition Diagnosis

<p>4. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.</p>
<p>5. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.</p>
<p>6. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.</p>

Estimated Needs:

Case #2 (First Encounter) continued...

Step #3: Nutrition Intervention

+ recommended diet/regimen)

Interventions: (actions &/or recommendations)

1.	_____
Goal(s)	_____
2.	_____
Goal(s)	_____
3.	_____
Goal(s)	_____
4.	_____
Goal(s)	_____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

1.	Indicator _____
Criteria	_____
2.	Indicator _____
Criteria	_____
3.	Indicator _____
Criteria	_____
4.	Indicator _____
Criteria	_____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Case Example #2: An underweight child (second encounter; 1 week later)

Step #1: Follow-up Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Indirect Calorimetry: REE = 75 kcal/kg, RQ 0.93 Labs within normal limits
<i>Anthropometric Measurements</i>	20 gram weight gain since admission 3 days ago
<i>Physical Examination Findings</i>	Patient still with mild stunting and wasting by Waterlow criteria.
<i>Food/Nutrition History</i>	Diet order: Pediatric solid food. Supplement of 1.5 kcal/ml beverage between meals tid
<i>Client History</i>	Patient admitted to acute care hospital for work-up of growth issues

Step #2: Nutrition Diagnosis

7. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
8. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
9. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.

Estimated Needs:

Case #2 Second Encounter continued...

Step #3: Nutrition Intervention

+ recommended diet/regimen)

Interventions: (actions &/or recommendations)

1.	_____
Goal(s)	_____
2.	_____
Goal(s)	_____
3.	_____
Goal(s)	_____
4.	_____
Goal(s)	_____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

1.	Indicator _____
Criteria	_____
2.	Indicator _____
Criteria	_____
3.	Indicator _____
Criteria	_____
4.	Indicator _____
Criteria	_____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Case Example #3: A man with cancer on a tube feeding (first encounter)

Step #1: Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Hemoglobin A1C: 6.2% Blood glucose G<140 Albumin 3.1
<i>Anthropometric Measurements</i>	Ht 5'6"; Wt: 92.3 kg; 10% weight loss over 2 months related to swallowing problems, but still 140% of ideal weight
<i>Physical Examination Findings</i>	
<i>Food/Nutrition History</i>	1.5 kcal/mL tube feeding (bolus feedings 6 times daily) provides 2250 kcal; 105 g protein; 1167 mL fluid; receives tap water flushes Liquids as tolerated
<i>Client History</i>	Medical history: Laryngeal Mass for radiation treatment. PEG placed 11/20/08; Diabetes treated with sliding scale insulin, hypertension, COPD sleep apnea Social history: Smoking and alcohol use. CF's belongings, trailer, and dog have been confiscated by his "friends". He is now homeless with placement issues due to lack of insurance.

Step #2: Nutrition Diagnosis

10. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
11. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
12. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.

Estimated Needs:

Case #3 continued...

Step #3: Nutrition Intervention

Nutrition Prescription: (nutrient needs + recommended diet/regimen)

Interventions: (actions &/or recommendations)

1.	_____
Goal(s)	_____
2.	_____
Goal(s)	_____
3.	_____
Goal(s)	_____
4.	_____
Goal(s)	_____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

1.	Indicator _____
	Criteria _____
2.	Indicator _____
	Criteria _____
3.	Indicator _____
	Criteria _____
4.	Indicator _____
	Criteria _____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

NCP Follow-up Webinar: Feb. 28, 2008

Case Example #4: 51 year old male

Step #1: Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Labs (2/28/08) Alb: 3.6 L, K+: 5.4, HGBA1C: 11.9
<i>Anthropometric Measurements</i>	Ht: 6'0" (182.9cm), Wt: 118.8lb. (54 kg) end of dialysis (dry wt) 129.8lb. (59 kg) before dialysis; 11lb. (5 kg) dialysis wt loss BMI 17.6 underwt IBW: 178lb. (80.9 kg), 73 % IBW
<i>Physical Examination Findings</i>	Appears thin. Skin intact.
<i>Food/Nutrition History</i>	Pt is unreliable. Unable to obtain accurate history.
<i>Client History</i>	Dx: CKD stage 5 started on hemodialysis 12/27/07 PMed Hx: IDDM since a teen, diabetic gastroparesis poorly controlled HTN, diabetic gastroparesis with significant diarrhea, anemia secondary to CKD and hyperphosphatemia related to diet and questionable compliance with, and access to, phosphate binders. Meds: lantus 5 units in am and humalog 2 units before meals. Pt is not symptomatic with low glucose and MD decreased insulin to avoid hypoglycemia. Pt is homeless and living with friends. He has applied for Medicaid and Medicare Part D coverage but these are pending. Pt is poor historian and information on diet, meds, and living arrangements is unreliable possibly due to long hx of extreme fluctuations in glucose and subsequent side effects. Pt has been hospitalized three times since initiation of tx.

Estimated Needs: ~2100 kcals/day (35 kcals/kg), 77 grams protein/day (1.3 g/kg)

Step #2: Nutrition Diagnosis

13. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____
14. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____
15. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____

Estimated needs:

Case #4 continued...

Step #3: Nutrition Intervention

Nutrition Prescription: (nutrient needs + recommended diet/regimen)

Interventions: (actions &/or recommendations)

1. _____ Goal(s) _____
2. _____ Goal(s) _____
3. _____ Goal(s) _____
4. _____ Goal(s) _____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

1. Indicator _____ Criteria _____
2. Indicator _____ Criteria _____
3. Indicator _____ Criteria _____
4. Indicator _____ Criteria _____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal

☐ Not Met ☐ Continue

Case Example #5: A woman with end of life issues (first encounter)

Step #1: Nutrition Assessment

Nutrition Assessment Categories	Case Example Indicators
<i>Biochemical Data, Medical Tests and Procedures</i>	Alb2.6; BUN 33; Creat 1.2.
<i>Anthropometric Measurements</i>	Ht: 5'4"; Wt:123#; Usual weight is 120#; Ideal weight is 120#; BMI is 20.9.
<i>Physical Examination Findings</i>	Skin intact with 3+ edema on all 4 extremities.
<i>Food/Nutrition History</i>	Estimated needs: 1300cal, 55gPro, 1375cc(x 25cc/kg) using 55.4kg. Diet order is regular with 3 oz 2.0 kcal/mL supplement BID. Taking about 50% of meals and at least120cc fluid/meal. Refuses some foods, supplements and appetite stimulant medications. No chewing problems, but some difficulty swallowing pills. Has no appetite; refuses food, supplements and Megace.
<i>Client History</i>	94 yr female with end stage CHF, pneumonia, pleural effusion, and severe PVD. Medications include Zaroxynl, 40 mg Lasix, Aldactone, Diovan, Megace 400mg (10cc) daily, lexapro. Social history: She has "Do not resuscitate" orders. Living will states no tube feedings. She states she is tired of living. Family and patient agree to hospice care; comfort measures only.

Estimated needs:

Step #2: Nutrition Diagnosis

16. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
17. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.
18. Problem _____ as related to Etiology _____ as evidenced by Signs/sympt. _____.

Case #5 continued...

Step #3: Nutrition Intervention

+ recommended diet/regimen)

Interventions: (actions &/or recommendations)

1. _____ Goal(s) _____
2. _____ Goal(s) _____
3. _____ Goal(s) _____
4. _____ Goal(s) _____

Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)

When/time frame you plan to reassess: _____

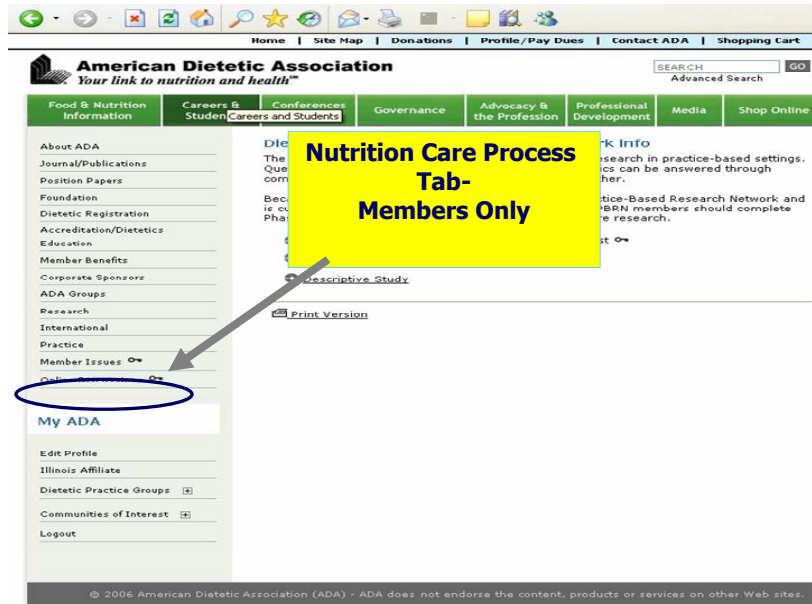
1. Indicator _____ Criteria _____
2. Indicator _____ Criteria _____
3. Indicator _____ Criteria _____
4. Indicator _____ Criteria _____

If a reassessment address goal progress:

Goal #1 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #2 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue

Goal #3 _____ ☐ Met ☐ Establish new goal
☐ Not Met ☐ Continue



In addition, there are many materials already on the ADA website that might be useful. Attached is a summary of the types of materials currently available at

http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_13838_ENU_HTML.htm

- On-Line Tutorial on NCP and Standardized Language (12 -10 minute modules)
- Nutrition Care Process and Model – Journal Article - 2003
- Nutrition Care Process and Model Diagram - 2003
- Sample Nutrition Services Policy and Procedure - 2004
- ADA Times Article: Step Out of the Comfort Zone: Teaching Nutrition Care Process and Model to Dietetics Students – 2004
- Examples of Applying the Nutrition Care Process and Model for Heart Disease in Different Practice Settings – 2004
- Adolescent Web Cases –PIPPAH (For educators only) – 2005
- Peer Network for Nutrition Diagnosis Members – 2005
- Nutrition Diagnosis: A Critical Step in Nutrition Care Process – 2005
- *Eight Stage Change Abstract and Implementation Checklist – 2006
- *Logic Model for Standardized Language
- *Chart Audit Tool
- Two cases showing multiple documentation formats

The Nutrition Care Process and Model – FAQs

1. What is the Nutrition Care Model?

The Nutrition Care Model is a graphic visualization that illustrates the steps of the Nutrition Care Process (NCP) as well as internal and external factors that impact application of the NCP. The central component of the Model is the relationship of the target patient, client, or group and the RD. One of two outer rings represents the skills and abilities of the RD along with application of evidence-based practice, application of the Code of Ethics, and knowledge of the RD. The second of two outer rings represents environmental factors such as healthcare systems, socioeconomics, and practice setting that impact the ability of the target group or client to benefit from RD services. Screening and referral and outcomes management are also components of the model (and will be discussed later in this document).

1. What is the Nutrition Care Process?

The NCP is a systematic approach to providing high quality nutrition care. It was published as part of the Nutrition Care Model. Use of the NCP does not mean that all patients get the same care. Use of a care process provides a framework for the RD to individualize care, taking into account the patient's needs and values and using the best evidence available to make decisions. Other disciplines in healthcare, including nurses, physical therapists and occupational therapists have adopted care processes specific to their discipline. In 2003, the House of Delegates (HOD) of the American Dietetic Association (ADA) adopted the NCP in an effort to provide dietetics professionals with a framework for critical thinking and decision-making. Use of the NCP can lead to more efficient and effective care and greater recognition of the role of dietetic professionals in all care settings.

2. What are the steps of the NCP?

The NCP consists of four distinct, interrelated steps. The process begins with **nutrition assessment**. Data collected during the nutrition assessment guides the RD in selection of the appropriate **nutrition diagnosis** (i.e., naming the specific problem). The RD then selects the **nutrition intervention** that will be directed to the root cause (or etiology) of the nutrition problem and aimed at alleviating the signs and symptoms of the diagnosis. The final step of the process is **monitoring and evaluation**, which the RD uses to determine if the patient/client has achieved or is making progress toward the planned goals. These processes are described in a circle but might also appear to be linear. However, we acknowledge that during the course of an interaction/appointment with a patient/client, the RD will often complete the assessment and diagnosis steps, and may begin a Nutrition Intervention when a patient reveals another piece of new assessment data/information that will cause the RD to re-assess, and re-diagnose and perhaps modify the plan that he/she had started discussing with the client.

3. Is use of the NCP required by ADA?

ADA strongly recommends incorporation of the NCP by dietitians in all care settings and it is now a required part of dietetic education, however RDs are not required to use the NCP. It is hoped that, once the value of the NCP is realized, RDs will choose to adopt it in their care setting. We are working with healthcare accrediting agencies, such as Joint Commission on Accreditation of Healthcare Organizations so that when they evaluate nutrition services they will use the NCP and Model as part of their process. We are also working with the informatics community to incorporate terms used in the NCP in electronic health records.

4. What's in it for me?

It depends on where and how you practice.

While there may be a significant time commitment in the initial implementation stages, use of the NCP can eventually save time by serving as a framework for decision-making and documentation regardless of the setting. The NCP will also allow development of large databases of information needed to demonstrate the value of the RD, which may lead to improved reimbursement. Therefore, the payoff to the individual RD is a higher likelihood for reimbursement, increased evidence supporting the value of the RD, and improved daily workflow.

If you are a clinical RD, the NCP will provide a framework for connecting data collected during nutrition assessment to each of the other steps. Decision-making will be facilitated by use of EBM. Use of the standardized language of dietetics will simplify documentation and provide a common understanding of the work that RDs do.

If you are an educator the NCP will provide a framework for teaching dietetics students how they provide nutrition care. It will also serve as a way to structure your student/intern evaluation forms to show that they can adequately address each step in the process.

If you are in community, you can use the NCP as the way you structure your grant applications by discussing the assessment of the community/population data, the type of nutrition diagnosis(es) (problem(s)) that you need to address, what types of interventions will be employed, and how you will monitor and evaluate the outcomes. The rest of the model will be useful in explaining the contextual factors that impact the whole process (the social systems, healthcare system, practice settings and economics. The second ring can describe the capabilities that a registered dietitian can bring to the project if you are intending to justify RD involvement.

If you are a Food and Nutrition Service Department director or Clinical Nutrition Manager in healthcare (either acute care or long term care) you

will find the NCP and Model useful in describing how the RD contributes to the overall healthcare provided in the institution. It is a pictorial model used to communicate among healthcare providers what the contributions of the RD are to the healthcare system when they provide nutrition care. It can be used to establish position description activities that are expected and serve as the framework for productivity measurement and performance evaluation of clinical dietetics and ambulatory staff.

If you are a research dietitian you can use the framework to think about the types of data that you will need to collect from each step in the process as well as how you will want to structure your intervention. It will be useful in describing the implications of research to practice.

5. Does the NCP apply to dietitians who are not in clinical practice?

It depends. The NCP and Model is based on the scientific problem solving method. Many of the principles are transferable, however the application is to those who are involved in providing nutrition care. Because the NCP acts as a framework for critical thinking and decision making, it can be utilized by RDs working in all settings that require these skills, including clinical, management, food service, research, community, and education. Every member of the dietetics profession needs to be able to describe what the NCP and Model is whether they “USE” it themselves on a daily basis, interact with other members of the profession who do or supervise those dietitians who use it daily or not. It describes what over 50% of our members do every day.

6. Will I need to change the way I practice?

It depends. Advances in practice generally require new knowledge and adjusted behaviors. Adoption of the NCP is no different in that regard. Since the NCP has emerged from the process of nutrition care used by dietitians, it is an enhancement rather than a complete change. The biggest difference is naming a specific nutrition diagnosis/problem and writing it in a special “PES statement” format. If you haven’t been used to using a nutrition diagnosis and PES statement, then this will be a change for you. Documentation can also be streamlined by the NCP and the use of the standardized terms. You will likely find that you will need more time to work through the documentation of clinical patient care when you start and therefore you may want to adjust your appointment schedules and workload while you are learning the new terms.

7. What does it cost to implement?

The main cost is the time necessary to implement and adjust to a new way of approaching nutrition care. Resources are available on the ADA website to help with training and implementation. Many, including slides, sample case studies and forms, can be accessed at no cost to ADA members. The manual, Nutrition Diagnosis and Intervention: Standardized Language for the Nutrition Care

Process (292 pages) can be downloaded from the ADA Members Only website free of charge and the new book that incorporates the nutrition intervention is available in hard copy at a nominal cost (\$15).

8. What is the nutrition diagnosis?

The nutrition diagnosis is the identification and labeling of a nutrition problem that the RD is responsible for treating independently. Standardized terminology for nutrition diagnosis has been developed to facilitate this step. Examples of nutrition diagnoses are: “inadequate energy intake”, “overweight/obesity”, “food and nutrition related knowledge deficit” and “limited access to food”. It is suggested that the RD use a PES Statement to communicate the nutrition diagnosis (problem, etiology, and signs/symptoms).

9. What is a PES Statement?

The PES statement names the **nutrition problem (P)**, identified its cause (or **etiology (E)**) and lists the assessment data (**signs and symptoms (S)**) that justify the problem. It is written as: nutrition diagnosis term “related to” etiology “as evidenced by” signs and symptoms of the nutrition diagnosis. This is a concise way of describing a nutrition problem that the RD is responsible for treating. A reference manual is available to assist in linking etiology and signs and symptoms with a specific nutrition diagnosis.

10. Must I write a PES statement every time I see a new patient?

If no nutrition problem is identified, then there is no need to write a PES statement. If you assess a patient that has been identified through a screening process and you determine that there is no immediate problem, then you would not write a PES statement and would not initiate an intervention.

11. What is a nutrition intervention?

The intervention is the purposeful action of the RD aimed at ameliorating or lessening the nutrition diagnosis. Common nutrition interventions have been categorized and defined in the reference manual. They include “supplements”, “nutrition related medication management”, “nutrition education”, and “nutrition counseling”.

12. How do I document the monitoring and evaluation step?

Dietitians should monitor outcome indicators that are relevant to the patient’s nutrition diagnosis and intervention goals. The “as evidenced by” signs and symptoms in the PES statement are appropriate things to monitor. Standardized terminology for monitoring and evaluation will be released in 2007.

13. Does the NCP affect charting?

The NCP can be worked into any charting or documentation system, however many dietitians are using the ADI or ADIME format which directly parallels the NCP (Assessment, **D**iagnosis, **I**ntervention, **M**onitoring and **E**valuation). It is

recognized that in many settings the RD might not have the ability to change the format for documentation. In spite of this, use of the NCP will allow RDs to focus their chart notes and make documentation more concise. The new publication shows examples of how the patient care would be documented using the ADI, SOAP, and Narrative format.

14. Will physicians understand the NCP and the way it is documented?

To date, feedback from physicians in various settings has been positive. More concise documentation with an explicitly stated nutrition diagnosis/problem and intervention plans to address the problem clarifies the dietitian's unique role in the patient's care. Use of the standardized terminology of dietetics has the potential to improve communication with physicians and other healthcare professionals through use of consistent definitions of terms used across settings. Many physicians are using electronic medical record systems that incorporate standardized terminologies and thus may have increased appreciation for dietitians' need for standardized terminology.

15. Why is screening not included in the NCP?

Nutrition screening is a means by which patients/clients are identified for nutrition care. Screening can be done by many different personnel, it does not require a dietetic professional, and therefore it is not part of the NCP. Nutrition screening is considered an "entry" step to the NCP and is included in the overall "Model", however it is not always completed by the RD or dietetic staff and therefore not part of the dietitian unique Nutrition Care Process.

16. What is the role of the DTR in the NCP?

The DTR works within their scope of practice and under the direction and clinical supervision of the registered dietitian in accordance with both state and federal guidance. The DTR may utilize the NCP as a framework for care of patients. Work is being done by various ADA Committees to more clearly describe how the DTR and RD interface in providing care throughout the Nutrition Care Process.

17. Will using the NCP make my work more effective and efficient?

Some have noted a temporary decrease in productivity as staff learns the process. However, once the NCP is fully implemented, dietitians report improvements in organization and prioritization of daily tasks resulting in greater efficiency. Improved effectiveness comes when the more systematic approach to care produces better outcomes which are brought to light through the monitoring and evaluation step.

18. What is meant by standardized terminology? Do I have to learn a new language to describe the work I do?

With the advent of nutrition diagnosis, work began on the development of a standardized language for the NCP. Terms used for nutrition diagnosis

and nutrition intervention have been identified, organized and defined and are available in a reference manual. Using standard terminology allows dietitians in all settings to use the same words to describe things resulting in more precise and effective documentation and communication. Standardized terminology is also essential for electronic medical records and billing forms. Standardized language will also facilitate legislative efforts.

19. Where do ADA's Evidence Analysis Library and Guides for Practice fit in?

ADA's Evidence Analysis Library and Evidence Based Guides for Practice are valuable resources that RDs can use throughout the NCP. They provide information that can guide selection of assessment methods and criteria and provide evidence for choosing the most effective intervention strategies and deciding what indicators to monitor. Evidence-Based Guides for Practice Toolkits that are available for purchase to support the Evidence Based Guidelines. Toolkits also contain sample forms that can be used for assessment, nutrition education and counseling, and documentation that follow the Nutrition Care Process and incorporate the standardized language.

20. Can I get paid more? Will this improve the chances that the hospital administration will recognize my value?

It is difficult, if not impossible to determine the impact of the NCP on RD salary levels. However, there is certainly the opportunity to use the NCP to demonstrate to administrators the positive outcomes associated with medical nutrition therapy by the RD. The hope is that someday we will have enough research/data to connect the various Nutrition Diagnoses and Interventions to outcomes and can begin to address the resources needed. Dietitians can then follow the model of the Medical Diagnostic codes which have been bundled and used to identify estimates of reasonable costs. We should be able to capture the complexity of the NUTRITION issues and corresponding resources needed to address them. When this occurs, then we will have sufficient data to address the reimbursement and payment systems.

21. How can I get more information?

ADA's member's only website front page has a link to many more documents and many resources for those interested in learning more about the Nutrition Care Process!