

Documenting in the Medical Record

Updated: December 2014

Overview: Professional Standards of Practice serve as the basis for quality dietetic practice for dietary managers. The standards that follow—updated in December 2014—provide guidelines for Certified Dietary Manager, Certified Food Protection Professionals to use when documenting food and fluid intake in the medical record.

Supplemental Material: Access the [Gap Analysis Tool](#) to supplement your practices.

Standard 1

The Certified Dietary Manager, Certified Food Protection Professional (CDM®, CFPP®) shall ensure that nutritional screening data is accurately obtained and recorded in the medical record in accordance with state and federal regulations and facility policy. The CDM, CFPP shall ensure that food and fluid-related interventions are added to client care plans.

CRITERIA

1.1 A policy is in place stating which qualified interdisciplinary team (IDT) member will ask client interview questions regarding factors influencing nutritional status. The policy will include how other family members or surrogate decision makers are to be included in the interview and care planning process and how this information is communicated to the IDT.

1.2 CDM, CFPPs will receive training to obtain nutritional screening information.

1.3 Nutritional screening data is obtained from client interviews and/or from surrogate decision makers in a timely manner that complies with facility policy and regulatory guidelines.

1.4 Nutritional screening includes documentation of food and fluid intake in the medical record.

1.5 Identification of nutritional problems are included in screening and documentation within the medical record. Examples of nutritional problems:

1. Client consistently leaves greater than 25 percent of meals uneaten,
2. Client does not consume adequate fluids on a daily basis,
3. Client does not have ability to chew, has mouth pain, or has signs and symptoms of a swallowing disorder,
4. Client has difficulty using regular feeding utensils or dinnerware,
5. Client is unable to feed self,
6. Usual dining routines, behaviors and appetite have significantly changed,
7. Client has experienced a significant change in weight.

1.6 Progress notes will reflect observation of a client's response to the dining environment (does the environment stimulate client to consume food and fluids and socialize with peers, etc.) and dining preferences.

1.7 Progress notes will reflect observation of a client's food and fluid intake and usual dining routines and behaviors.

1.8 Nutritional interventions are care planned with appropriate participation of IDT members to address family, staff, or client's nutritional concerns.

1.9 CDM, CFPPs collaborate with the dietitian* and client in establishing goals and approaches for a client's nutritional care plan that are routinely monitored, reviewed, and revised.

1.10 CDM, CFPPs use standardized forms for documenting data obtained from the nutritional screen (such as components of the Resident Assessment Instrument (RAI): Minimum Data Set (MDS), Care Area Assessment (CAA), and care plan).

1.11 All medical records are legal documents. With use of an electronic health record (EHR) system, electronic signatures are acceptable. Following are guidelines for an EHR system:

1.11.1 The healthcare facility has a written protocol describing the attestation policy in force at the facility.

1.11.2 Each person responsible for an attestation has an individual identifier.

1.11.3 The EHR has built-in safeguards to minimize the possibility of fraud and HIPAA violation.

1.11.4 The date and time is recorded from the computer's internal clock at the time of entry.

1.11.5 The EHR system controls what actions and areas an individual can access or enter data, based on the individual's personal identifier.

1.12 In cases where facilities use a paper medical record, entries will be in black ink, dated, signed with full name and title, and never backdated or erased. Medical record errors are connected by a one-line strike out, initialed, dated, and labeled "error".

ASSESSMENT

1.1 Copies of recent surveys indicate compliance with regulatory guidelines regarding documentation in the medical record. Problem areas are noted and plans of correction are developed by the CDM, CFPP in collaboration with the dietitian and facility administrator.

1.2 Standardized assessment forms are available and acknowledged by the CDM, CFPP and dietitian.

1.3 Standardized parameters for anthropometric, biochemical, physical exam, and client history data have been established by the facility and approved by the dietitian. (Examples of parameters can be found in the following document: Nutrition Diagnosis and Intervention: Standardized Language for the Nutrition Care Process by the Academy of Nutrition and Dietetics.)

1.4 Sufficient documentation of a client's progress toward achieving care plan goals exists in the medical record.

1.5 Documentation in the medical record is routinely audited for accuracy and appropriateness per facility policy.

1.6 Records of staff training with objectives based on performance improvement and competence are filed within the facility.

1.7 The CDM, CFPP maintains required credentials and records of continuing education (CE) within the facility.

Standard 2

The Certified Dietary Manager, Certified Food Protection Professional (CDM, CFPP) shall ensure that procedures for documenting nutritional assessment are established according to regulatory agency guidelines and facility policy.

CRITERIA

1.1 The CDM, CFPP participates in the nutrition care process (NCP) and collaborates with the dietitian to establish nutritional screening and assessment documentation policies and procedures.

1.2 The nutrition assessment documentation policy identifies who fills out what sections of standardized forms used for assessment (such as components of the Resident Assessment Instrument (RAI): Minimum Data Set (MDS), Care Assessment Area (CAA) and care plan) and how this information is communicated to the IDT.

1.3 CDM, CFPPs document nutritional screening data such as observed food and fluid intake, calculation of nutrient intake, heights, weights, lab values, changes in diagnosis or health status, oral health, or other nutritional problems and nutritional status parameters for further assessment by the dietitian.

1.4 All medical records are legal documents. With use of an electronic health record (EHR) system, electronic signatures are acceptable. Following are guidelines for an EHR system:

1.4.1 The healthcare facility has a written protocol describing the attestation policy in force at the facility.

1.4.2 Each person responsible for an attestation has an individual identifier.

1.4.3 The EHR has built-in safeguards to minimize the possibility of fraud and HIPAA violation.

1.4.4 The date and time is recorded from the computer's internal clock at the time of entry.

1.4.5 The EHR system controls what actions and areas an individual can access or enter data, based on the individual's personal identifier.

1.5 In cases where facilities use a paper medical record, entries will be in black ink, dated, signed with full name and title, and never backdated or erased. Medical record errors are corrected by a one-line strike out, initialed, dated, and labeled "error."

ASSESSMENT

1.1 Facility policy for nutritional screening and assessment is acknowledged by the CDM, CFPP and dietitian and is on file within the foodservice department.

1.2 Standardized forms for nutritional assessment are available and acknowledged by the CDM, CFPP and dietitian.

1.3 The nutrition assessment documentation policy ensures clearly defined roles for the CDM, CFPP and dietitian in documentation for all areas of the Resident Assessment Instrument (RAI).

1.4 Standardized parameters for anthropometric, biochemical, physical exam, and client history data have been established by the facility and approved by the dietitian. (Examples of parameters can be found in the following document: Nutrition Diagnosis and Intervention: Standardized Language for the Nutrition Care Process by the Academy of Nutrition and Dietetics.)

1.5 Sufficient documentation of a client's progress toward achieving care plan goals exists and rationale for changes in plan of care are documented in the medical record by the CDM, CFPP and dietitian.

SUMMING IT UP

For the CDM, CFPP participating in collaborative dietetics, practice standards serve as guidance for documenting in the medical record. Reference to the standards provides assistance in development of facility policies regarding nutritional screening and assessment of clients.

References

Susan Davis Allen, MS, RD, CHE is the original author of this Standard. Allen, a former dietary manager program director, served as an advisor to the Certifying Board for Dietary Managers for many years. This Standard was revised by Brenda Rubash, RD, LD in December 2014. Rubash is a consultant dietitian and an instructor for the Nutrition and Foodservice Professional Training Program at the University of North Dakota in Grand Forks.

Zikmund, Julie. *Nutrition Fundamentals and Medical Nutrition Therapy*. St. Charles, IL: Association of Nutrition & Foodservice Professionals, 2018.