Association of Nutrition & Foodservice Professionals

Tips for Documenting in the Medical Record

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1. Ensure Policies and Procedures are in Place: The CDM, CFPP participates in the nutrition care process and collaborates with the dietitian to establish nutritional screening and assessment documentation policies and procedures. The policies state which qualified interdisciplinary team member will ask client interview questions regarding nutritional status, the care planning process, and how this information is communicated to the interdisciplinary team.

2. Complete Training and Maintain Your Credentials: CDM, CFPPs receive training on navigating the electronic medical records and how to obtain nutritional screening information. Records of staff training are filed within the facility. The CDM, CFPP maintains required credentials and continuing education within the facility.

3. Use Standardized Forms: CDM, CFPPs document using standardized forms such as components of the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), Care Area Assessment (CAA), and care plan. Standardized parameters for anthropometric, biochemical, physical exam, and client history data have been established by the facility and acknowledged by the CDM, CFPP and the dietitian.

4. Interview the Client: Nutritional screening data is obtained from client interviews in a timely manner that complies with your facility policy and regulatory standards. CDM, CFPPs document 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 status parameters for further assessment by the dietitian.

5. Identify Nutritional Problems: Through interviewing and observation, identify nutritional problems. Examples include:

- Consistently leaves greater than 25% of meals uneaten
- Does not consume adequate fluids on a daily basis
- Chewing, mouth pain, swallowing problems
- Difficulty using feeding utensils or dinnerware
- Unable to feed self
- Usual routines, behaviors and appetite have significantly changed
- Significant change in weight
- Skin breakdown

6. Document the Client's Response: Progress notes reflect the observation of a client's response to the dining environment and dining preferences, food and fluid intake, and usual dining routines and behaviors.

7. Maintain a Care Plan: Nutritional interventions are care planned with appropriate interdisciplinary team members to address family, staff, or the client's nutritional concerns. CDM, CFPPs collaborate with the dietitian and client to establish goals and approaches for a nutritional care plan that are routinely monitored, reviewed, and revised.

8. Document Progress: Sufficient documentation of progress toward achieving care plan goals and the rationale for changes in plans of care are documented by the CDM, CFPP and the dietitian.

9. Follow Medical Record Guidelines: Medical records are legal documents. An electronic health record system has:

- A written protocol describing the attestation policy in force
- An individual identifier for each person responsible for an attestation
- Built in safeguards to minimize the possibility of fraud and HIPAA violation
- Date and time recorded from the computer's internal clock at time of entry
- Control of areas and actions an individual can access or enter data

*If using paper medical records, entries are in black ink, dated and 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."

10. Audit Medical Records: 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. Routine audits are completed for accuracy and appropriateness per facility policy.