Implementing Nutrition Diagnosis
At a Multisite Health Care Organization

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ABSTRACT

The American Dietetic Association Nutrition Care Process (NCP) is designed to improve patient care and interdisciplinary communication through the consistent use of standardized nutrition language. Supported by Dietitians of Canada, the NCP has been gaining prominence across Canada. In spring 2009, registered dietitians at Providence Health Care, an academic, multisite health care organization in Vancouver, British Columbia, began using the NCP with a focus on nutrition diagnosis. The success of nutrition diagnosis at Providence Health Care has depended on support from the Clinical Nutrition Department leadership, commitment from the NCP champions, regularly scheduled lunch-and-learn sessions, revised nutrition assessment forms with a section for nutrition diagnosis statements, and the *Pocket Guide for International Dietetics & Nutrition Terminology (IDNT) Reference Manual*. Audit results from June through August 2010 showed a 92% nutrition diagnosis completion rate for acute-care and long-term care sites within Providence Health Care. Ongoing audits will be used to evaluate the accuracy and quality of nutrition diagnosis statements. This evaluation will allow Providence Health Care dietitians to move forward with nutrition intervention.

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RÉSUMÉ

Le processus de soins en nutrition (PSN) de l'American Dietetic Association est conçu pour améliorer les soins aux patients et la communication interdisciplinaire au moyen d'une utilisation cohérente et uniforme d'une terminologie normalisée en nutrition. Les diététistes du Canada soutiennent le PSN, et ce dernier est de plus en plus adopté à l'échelle nationale. Au printemps 2009, les diététistes de Providence Health Care, une organisation universitaire de soins de santé multisites de Vancouver, en Colombie-Britannique, ont commencé à utiliser le PSN en axant leurs démarches sur le diagnostic nutritionnel. Le succès du diagnostic nutritionnel de Providence Health Care s'explique par le soutien qu'a offert la direction du service de nutrition clinique; l'engagement de champions du PSN; la tenue régulière de dîners-conférences; des formulaires d'évaluation de la nutrition révisés, qui comportent une section pour la formulation du diagnostic nutritionnel; et le guide pratique du manuel de référence sur la terminologie internationale de diététique et de nutrition (TIDN). Les résultats de l'audit réalisé entre juin et août 2010 indiquent que dans 92 % des cas, des diagnostics nutritionnels ont été complétés dans les établissements de soins de courte durée et de longue durée de Providence Health Care. D'autres audits seront utilisés afin d'évaluer la précision et la qualité des énoncés contenus dans le diagnostic nutritionnel. Cette évaluation permettra aux diététistes de Providence Health Care d'aller de l'avant avec les interventions nutritionnelles.

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INTRODUCTION

The Nutrition Care Process (NCP) is a comprehensive, four-step tool developed by the American Dietetic Association (ADA) in 2003 (1). The NCP is supported by Dietitians of Canada (DC), and its use is gaining momentum in Canada (2). The aims of the NCP are to facilitate consistent, high-quality patient care through the use of standardized nutrition language, to facilitate decision-making, and to make the monitoring of patient outcomes easier (1). Moreover, the NCP has been vital in the revision of American dietetic standards of practice (3).

As was demonstrated early in the development of the NCP, adoption of and adherence to standardized clinical language are enhanced by continuous inservice education (4). Embracing change is difficult, and "increased knowledge about a subject does not necessarily add up to increased motivation for behavioral change" (5). The process can be smoother with "peer coaches" and group discussions (5).

PURPOSE AND METHODS

Providence Health Care, an academic, multisite health care organization, implemented nutrition diagnosis and standardized nutrition language. This organization is one of the largest faith-based health care organizations in Canada, operating 14 sites in Vancouver, British Columbia. Fifty registered dietitians (RDs), equal to 40 full-time equivalents, work in various capacities across Providence Health Care's acute- and long-term care sites. In addition, Providence Health Care annually hosts five University of British Columbia-based dietetic interns for a 10-month internship.

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In spring 2009, the professional practice leader of the Clinical Nutrition Department at Providence Health Care introduced the NCP to the RDs. The RDs subsequently participated in a nutrition diagnosis workshop led by a Canadian expert on the NCP. The workshop featured the following key nutrition diagnosis learning activities:

- Recognizing the differences between the intake, clinical, and behavioural-environmental domains.
- Becoming familiar with common nutrition diagnostic terminology.
- Understanding the distinction between etiology and signs/symptoms.
- Constructing simple problem-etiology-signs/symptoms (PES) statements based on Providence Health Care-specific case studies provided to the facilitator in advance.

This workshop laid the foundation for RDs to implement the NCP.

Over the next few months, the Clinical Nutrition Department acquired copies of the *Pocket Guide for International Dietetics & Nutrition Terminology (IDNT) Reference Manual* (6). Manuals were distributed to acute-care RDs in each specialty area and at all long-term care facilities. At the same time, members of the Clinical Nutrition Professional Practice Council alternated as facilitators for lunchtime nutrition diagnosis learning sessions. The council consists of RDs representing various work areas, who help support the integration, standardization, and coordination of dietetic clinical practice within Providence Health Care.

The objectives of the nutrition diagnosis lunch-and-learn sessions were to engage RDs and sustain their involvement in the NCP process, and to provide colleague-based support and leadership. The lunches provided an open forum for discussion of real-life case studies and the composition or revision of PES statements. At these lunch meetings, NCP questions, concerns, and challenges were addressed and explored in an open environment. At least one member of the Clinical Nutrition Professional Practice Council attended these lunches and facilitated the sessions. The RDs were encouraged to bring challenging case studies from their own work; the facilitating council member was responsible for one or two "back-up" case studies for discussion.

The lunch-and-learn sessions were initially held weekly. To encourage attendance early in the implementation of the NCP, participants' names were entered into a monthly draw for a small prize. As RDs embraced the NCP, the frequency of the lunches decreased to biweekly and then monthly. The lunch-and-learn sessions were informally evaluated by the Clinical Nutrition Professional Practice Council at their biweekly meetings. The council routinely assessed the participation rate, the depth of discussion, and topics for future sessions.

As the Clinical Nutrition Department moved forward with the NCP, recurrent questions and concerns emerged about the formulation of PES statements. To address these challenging PES statements, in fall 2009 the Professional Practice Council participated in a teleconference with a Canadian NCP expert. The teleconference confirmed that RDs in other parts of Canada had similar questions and concerns. The teleconference provided the Providence Health Care RDs with useful diagnostic terminology.

At about the same time, the Professional Practice Council revised the Clinical Nutrition Department assessment forms to incorporate space for the nutrition diagnosis. From October 2009 to July 2010, the Providence Health Care Forms Committee approved the updated assessment forms individually. The program-specific nutrition assessment forms include those on acute care, cystic fibrosis, diabetes, eating disorders, elder care, healthy heart, and nutrition support.

In September 2009, the 2009 to 2010 Providence Health Care dietetic intern cohort received an introductory session on nutrition diagnosis as a component of nutrition assessment. Because the interns had received basic NCP education through the University of British Columbia, this session was designed as a refresher as they prepared for their clinical placements.

RESULTS AND DISCUSSION

In late July 2010, an informal e-mail survey was conducted with all Providence Health Care dietitians who hosted dietetic interns from September 2009 to June 2010. Fourteen of 22 (64%) RDs who acted as primary preceptors participated. Approximately 50% of Providence Health Care dietitians discussed nutrition diagnosis with their intern(s), encouraged them to complete PES statements, and reviewed the PES statements when appropriate. The primary reasons that preceptors did not engage interns in nutrition diagnosis were the use of unrevised nutrition assessment forms and an observation-only placement objective. The survey confirmed the importance of revised nutrition assessment forms with a section for nutrition diagnosis.

A June to August 2010 audit of Providence Health Care acute and residential sites revealed that 92% of patients/residents with an updated assessment form had a recorded nutrition diagnosis. The audit was conducted primarily by members of the Professional Practice Council, only in areas with a revised nutrition assessment form in place for at least six months. The breakdown of charts audited and success rates is as follows:

- 60 inpatient charts—90%.
- Six rehabilitation inpatient charts—100%.
- 28 outpatient charts—96%.
- 17 residential charts—88%.

Auditors noted the "problem" component of the nutrition diagnosis, but did not qualitatively analyze the PES statement. In certain patient populations, specific themes could be seen. The following nutrition diagnosis problems were most common:

- Medical, surgical, and cardiac inpatients—inadequate oral food/beverage intake (intake domain [NI] 2.1) in 31% and inadequate protein-energy intake (NI 5.3) in 35%.
- Cystic fibrosis outpatients—increased nutrient needs (NI 5.1) in 60%.
- Eating disorders inpatients—malnutrition (NI 5.2) in 80%.
- Renal outpatients—inadequate oral food/beverage intake (NI 2.1) in 16%, excessive intake of phosphorus (NI 5.10.2) in 16%, and a food- and nutrition-related knowledge deficit (behavioural-environmental domain [NB] 1.1) in 32%.

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- Long-term care residents—inadequate energy intake (NI 1.4) in 24% and no nutrition diagnosis in 35%.

The audit confirmed the value of updating the nutrition assessment forms to include a specific section in which to record the nutrition diagnosis. Although qualitative data were not specifically gathered in the audit, many auditors noted opportunities for improvement around the selection of "problem" phrases and the construction of PES statements in general. This finding highlighted the need for further education on qualitative data. The Professional Practice Council predicts that, now the nutrition assessment forms have been updated, both RDs and dietetic interns will have the opportunity to develop their nutrition diagnosis skills further.

Recently, the nutrition diagnosis lunches have been modified to target specific diseases, such as diabetes or renal disease. This targeting has motivated RDs to showcase and share their inventory of disease-specific PES statements. These themed lunches have encouraged RDs to think critically and have attracted a handful of RDs who have yet to embrace nutrition diagnosis fully. In addition, approximately 50% of RDs from all sites attended the recent ADA Practical Application of the Nutrition Care Process to Critically Ill Patients teleseminar. This is a higher turnout than for all the nutrition diagnosis lunch-and-learn sessions.

A compendium of sample medicine- and renal-specific PES statements resides on a dietitian-shared network available to all Providence Health Care RDs. The intent of these lists is to provide nutrition diagnosis-based guidance to dietetic interns, dietitians working on a casual basis, and dietitians new to these programs. The Clinical Nutrition Department is striving for a full complement of program-specific PES statement inventories.

To continue fostering NCP development and commitment within the Clinical Nutrition Department, the Professional Practice Council will keep engaging RDs through the following actions:

- Introducing new nutrition diagnostic terminology as it becomes available.
- Acquiring updated editions of the *Pocket Guide for International Dietetics & Nutrition Terminology (IDNT) Reference Manual* (6).
- Participating in NCP learning opportunities via workshops, teleseminars, and conferences.
- Conducting qualitative audits of PES statements, starting at regular intervals.
- Implementing nutrition intervention terminology.
- Facilitating themed lunch sessions on nutrition diagnosis, with the eventual introduction of lunch sessions on nutrition intervention.
- Supporting interns during orientation and clinical placements.
- Incorporating the NCP into the Providence Health Care standards of practice.

In addition to undertaking the RD engagement strategies above, hospitals and health care organizations wishing to implement the NCP might take the following measures to achieve dietitian engagement and momentum:

- Ensure steadfast support from clinical nutrition leadership.
- Demonstrate commitment from NCP champions.
- Modify all nutrition assessment forms to include a nutrition diagnosis and possibly other components of the NCP.
- Ensure enough pocket guides (6) are available for staff.

At Providence Health Care, barriers to the implementation of nutrition diagnosis are largely related to engagement and time constraints. Dietitians tend to have demanding workloads that do not leave much room for flexibility. Practising according to status quo methods is often easier than challenging oneself with a new thought process and novel charting techniques. Commitment to the NCP requires willingness to change and dedication. By following and adjusting RD engagement strategies to suit the needs of a particular hospital or health care organization, anyone can proceed with successful NCP implementation.

The implementation of nutrition diagnosis has been an exciting journey for the RDs at Providence Health Care. As with other novel changes in practice, this has been a lengthy process, and more work remains to be done. The Clinical Nutrition Department looks forward to moving ahead with standardized nutrition language for the remaining components of the NCP, beginning with nutrition intervention.

RELEVANCE TO PRACTICE

The NCP is a systematic method of providing quality patient care in clinical nutrition. The process is endorsed by both the ADA and DC, as part of an effort to promote standardized clinical nutrition language. Although not an approach to standardizing practice, the NCP leads to a standardized clinical nutrition note, and thereby summarizes key points for nutrition monitoring. The formation of clear, concise nutrition messaging permits seamless patient care among dietitians. Finally, the use of standardized nutrition language with the NCP is an ideal complement to electronic charting (5). This complementary use of the NCP and electronic charting will contribute to the goal of patient-centred, goal-oriented, efficient nutrition care.

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