INTRODUCTION TO NUTRITION CARE PROCESS

DEFINITION OF NUTRITION CARE PROCESS, STEPS OF NUTRITION CARE PROCESS

The Nutrition Care Process (NCP) is designed to improve the consistency and quality of individualized care for patients/clients or groups and the predictability of the patient/client outcomes. It is not intended to standardize nutrition care for each patient/client, but to establish a standardized process for providing care. To provide the best quality of care as a dietitian, one must be aware of nutrition and dietetics. Nutrition Care Process provides a structured approach that can be personalized to meet the needs of all patients or clients.

The framework of the Nutrition Care Process supports decision-making and critical thinking while ensuring efficient and effective care is provided. When providing the utmost care to clients or patients there are always steps or a process to guide and ensure quality.

The Nutrition Care Process is comprised of four steps:

- NUTRITION ASSESSMENT AND REASSESSMENT
- NUTRITION DIAGNOSIS
- NUTRITION INTERVENTION
- NUTRITION MONITORING AND EVALUATION

What is the ABCD of nutrition care process?

ABCDs of the Nutritional Assessment

Different components of a complete nutritional assessment ABCD*:* **anthropometric, biochemical, clinical, and dietary.**

In 2002, the Academy of Nutrition and Dietetics (formally American Dietetic Association), created the Nutrition Care Process (NCP) as a way to improve consistency and quality of individualized care for residents and the predictability of resident outcome. The goal of NCP is to standardize a process for providing nutrition care. There are four steps involved in the NCP to form a framework for the RD to create an individualized nutrition plan.

Step 1: Nutrition Assessment.

The Nutrition Assessment has two parts. Part 1 is the initial assessment which is a time to collect imperative data, background, and history and then analyze and interpret the data. Part 2 is the reassessment and is where the cycle we call the Nutrition Care Process starts over. The key date to be obtained/collected during the Nutrition Assessment include- Food/Nutrition History:

- Meal and snack patterns
- Adequacy of intake/change in appetite
- Nausea, vomiting

- History of bingeing, purging
- Physical activity patterns
- Food availability
- Food allergies/preferences
- Client History:
- Medical/surgical
- Medications/supplement usage/diet pills
- Vital signs/history of current illness
- Socioeconomic status
- Bowel habits, history of laxative use
- Anthropometric Data/Measurements:
- Height
- Weight (current, usual, ideal)
- Body weight index (BMI)
- Unintentional or intentional weight change
- Medical Procedures, Laboratory Data, and Test Results:
- Gastric emptying studies
- Bone scans
- Electrolytes
- Glucose/Haemoglobin A1C
- Lipid Profile
- Nutrition-Focused Physical Examination:
- Overall musculature, adipose stores
- Oral (tongue, gums, lips, mucus membranes, etc.)
- General physical appearance

Once the initial data, history, and background are collected it is time to review and assess factors that affect nutrition and health status. After data is assessed, the next step is identifying the nutrition problem or diagnosis

Step 2: Nutrition Diagnosis

The Nutrition Diagnosis or Diagnoses identifies nutrition problems that the nutrition professional or dietitian is responsible for treating. From the data collected and analyzed in the Nutrition, Assessment practitioners can identify what the nutrition diagnoses are.

Once diagnoses are understood recommendations can be presented to a patient. From there, a patient or clients can work with the practitioner to set goals to move towards for the betterment of their health.

When creating a nutrition diagnosis statement, specific nutrition diagnostic terms and the aetiologies, signs, and symptoms will be identified. There are three parts to a nutrition diagnosis statement.

Aetiology is a factor that contributes to a problem including pathophysiological, situational, developmental, cultural, and/or environmental. Signs and symptoms supporting the existence of the nutrition diagnosis. Nutrition Diagnosis should be clear and concise and always specific to the patient or client being treated. It is important to note that the nutrition diagnosis is not a medical diagnosis. The nutrition diagnosis statement should be clear, concise, related to one problem and based on reliable, accurate assessment data.

Step 3: Nutrition Intervention

The third step includes planning and implementing a plan focused on the nutrition problem identified in the nutrition diagnosis. This step includes discussing with the resident and other members of the interdisciplinary team realistic goals and creating a plan to reach that goal. Often in the long-term care setting, interventions may include speech therapy referral, altered diet texture or consistency, diet liberalization and providing nutrient dense supplements

The Nutrition Intervention is a set of planned actions with the intention of aiding in the healing process. Interventions may support changing nutrition-related behaviour, risk factor, environmental condition, or health status. All nutrition interventions should be SMART:

- S=Specific
- M=Measurable
- A=Attainable
- R=Relevant
- T=Time-based

Again, it cannot be stressed enough how important it is to include the patient. Working with the patient to overcome barriers and roadblocks is imperative.

Step 4: Nutrition Monitoring and Evaluation

Nutrition monitoring and evaluation is the time to implement the reassessment process. Essentially, this takes us back to the start. In reassessing the patient, all self-monitoring data and records will be reviewed to assess progress and if current goals or interventions are being met. This leads back into the cycle we call the Nutrition Care Plan.

The final step is monitoring the progress that has been made by the resident. This final step links back to the first step as the dietitian assesses the progress made in weight status, meal intake, labs, and nutrition-focused physical findings. More frequent nutrition monitoring is completed if the patient is at a higher nutritional risk such as decreased meal intakes, weight changes, skin alterations or receiving nutrition through tube feeding or TPN.

Back to Step 1: Reassessment

After the initial nutrition assessment is completed, the next step is scheduling and completing the reassessment. During the reassessment all data will be reviewed, past goals looked at, and patient or clients worked with to explore what they feel is going well and what may have been

more difficult. As a practitioner, one has to act as a guide, while the patient is driving their recovery.

During the reassessment, the practitioner will re-examine if goals are being met and if there is a need for adjustment or revision to goals or Nutrition Diagnoses.

This cycle will continue if the nutrition professional identifies a need for ongoing nutrition care. This may also be a time to identify when a patient is ready to progress to a different level of care or discharge.