

## Evaluating Documentation of Dietetic Care in Swedish Medical Records

Elin Lövestam<sup>a</sup>, Ylva Orrevall<sup>b</sup>, Afsaneh Koochek<sup>c</sup>, Brita Karlström<sup>a</sup>, Agneta Andersson<sup>a</sup>

<sup>a</sup> Department of Food, Nutrition and Dietetics, Uppsala University, Sweden

<sup>b</sup> Department of Learning, Informatics, Management, and Ethics, Karolinska Institutet, Sweden

<sup>c</sup> Department of Public Health and Caring Science, Uppsala University, Sweden

### Abstract

An adequate documentation in medical records is essential for patient safety and high quality care. The aim of this study was to evaluate documentation by dietitians in Swedish medical records. A retrospective audit of 147 dietetic notes in electronic medical records was performed. The audit focused at documentation of essential parts of the dietetic care, as well as other quality aspects such as lingual clarity and structure of the documentation. The nutrition intervention showed to be the most documented part of dietetic care. However, the audit showed that several important parts of nutrition care were poorly documented, for instance nearly half of the audited records had no clear nutrition problem documented, and in most of the records, the goal of nutrition intervention was missing. The study shows that Swedish dietitians need to improve documentation in medical records, as a suggestion by implementing a more structured documentation model.

**Keywords:** Medical records, audit, dietetics, documentation

### Introduction

High quality documentation and structured communication among health care professionals is essential to patient-safety, as it facilitates the continuity of care, the coordination of the treatment and the evaluation of patient outcomes [1]. High quality documentation is considered to be patient centered and to contain all essential parts of the given care in a logical and sequential manner [2]. Documentation is widely studied among nurses, but studies are still lacking among dietitians.

The aim of this study was to evaluate the quality of documentation in medical records by Swedish dietitians.

### Methods

A retrospective audit of 147 dietetic notes in Swedish electronic medical record was performed. The dietetic notes were systematically collected and written in 2009 by dietitians in four hospitals and six primary care centers in central Sweden. The instrument "Diet-NCP-Audit" was used auditing the medical records. The Nutrition Care Process is a structured framework for dietetic care and identifies the four essential parts of dietetic care as Assessment, Diagnosis, Intervention and Monitoring and evaluation [3]. The audit instrument contains 13 items, covering the essential parts of nutrition care as identified by the Nutrition Care Process, as well as other quality aspects such as lingual clarity and structure of the documentation. Each item is ranked 0-2 points, depending on the quality of the documentation. The maximum total score is 26 points. The instrument has recently been tested, showing high validity and moderate to high reliability.

### Results

The median total score of the audited records was 14.5, with a range between 8 to 21 points. Of the 147 medical records, 56 % contained a clearly documented nutrition problem. Intervention was clearly documented in 90 %, though a goal for the intervention was missing in 76 % in the audited records. Information of whether or not monitoring and evaluation was planned was documented in 70 % of the medical records, but only in 24 % information of which parameters to evaluate was found. Regarding the structure of the records, 29 % followed the sequential manner of assessment-diagnosis-intervention-evaluation. Of the audited records, 72 % had flaws in clarity, such as confusing formulations and own abbreviations.

### Discussion

The audit showed that Swedish dietitians need to improve documentation of several of the essential parts of dietetic care. Documentation was often fragmentary and inconsistent, with important parts of the dietetic care missing. For instance, intervention goals and evaluation parameters are important for evaluating the given care, and if these parts of dietetic care are missing in the documentation, the interventions cannot be evaluated in a reliable way. Earlier studies have shown that the implementation of standardized documentation models through education sessions, training and individual supervision improve documentation of essential parts of the care [4]. Therefore, a suggestion is that Swedish dietitians need to implement a more structured and standardized model of documentation, increasing patient safety and quality in care.

### References

- [1] Saranto K and Kinnunen UM. Evaluating nursing documentation - research designs and methods: systematic review. *J Adv Nurs*. 2009; 65(3): 464-476.
- [2] Jefferies D, Johnson M, and Griffiths R. A meta-study of the essentials of quality nursing documentation. *International Journal of Nursing Practice*. 2010; 16(2): 112-124.
- [3] Bueche J, Charney P, Pavlinac J, et al. Nutrition care process and model part I: the 2008 update. *J Am Diet Assoc*. 2008; 108(7): 1113-1117.
- [4] Hakel-Smith N, Lewis NM, and Eskridge KM. Orientation to nutrition care process standards improves nutrition care documentation by nutrition practitioners. *J Am Diet Assoc*. 2005; 105(10): 1582-1589.

Contact email – elin.lovestam@ikv.uu.se