University Hospitals of Leicester NHS
NHS Trust

Clinical Dietetic & Nutrition Service Documentation in Patients' Health Records Policy (In all Media)

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KEY WORDS

Documentation, record keeping, Dietetics & Nutrition, electronic handover, dietetic records, medical notes

1 INTRODUCTION AND OVERVIEW

This Policy sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the Nutrition & Dietetic Service Clinical Documentation in all media, inclusive of medical and nursing notes, electronic handovers and discharge electronic handover to other NHS Provider Trusts.

Record keeping is an essential and integral part of patient care. The purpose of the record is to give comprehensive, accurate and justifiable account of the care, treatment and support provided or planned for a patient.

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 All Dietitians, Dietetic Assistant Practitioners, Dietetic Admin Staff, Nutrition Nurses, Dietetic Assistants/Dietetic Support Staff employed by UHL NHS Trust.

2.2 All Dietetic undergraduate students on clinical placement with University Hospitals of Leicester NHS Trust from Nottingham University and other Health Education Institutions (HEI's).

2.3 This Policy applies to the Dietetic and Nutrition Service working in all Clinical Management Groups (CMG's) in all specialities and sub-specialities within University Hospitals of Leicester NHS Trust, on and off site. All Dietetic and Nutrition Service staff will document entries directly into the main medical/MDT health care records

2.4 All staff should have the importance of documentation discussed at corporate and local induction into the Trust and should adhere to professional standards as set out by the HCPC and BDA. Information Governance mandatory training is also essential annually. It will also form a core compotent of Preceptorship for all newly employed band 5 Dietitians.

3 DEFINITIONS AND ABBREVIATIONS

3.1 BDA – British Dietetic Association

3.2 An **electronic health record** for the purpose of this Policy refers to where clinical staff enter information regarding a patient's care or treatment

3.3 HCPC – Health Care Professions Council

3.4 NMC – Nursing Medical Council

3.5 A **health record** is the document that describes aspects of a patient's health care episode.

3.6 A **paper health record** is commonly referred to as 'case notes' and is currently where most patients' care and treatment is documented. This includes nursing notes which may be kept at the patients' bedside during their stay and will then be filed as part of the case notes on discharge.

4 ROLES – WHO DOES WHAT

4.1 Responsibilities within the Organisation

a) The Executive Lead for this Policy is the Chief Nurse.

b) Head of Service is responsible for implementing the Trusts capability policy with individual staff whose performance does not meet standards with HR support.

c) Dietetic and Nutrition Service clinical audit leads are responsible for overseeing service audit programmes in relation to documentation. See section 8 for full details.

d) All line managers are responsible for ensuring the staff they line manage adhere to this Policy and if non-adherence is identified an action plan is put into place immediately.

e) All dietetic and nursing staff are individually responsible for adhering to this Policy as part of their professional registration requirements.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

The overarching standards are set by the Health Care Professions Council as part of professional registration requirements for Dietitians. The documents published by the British Dietetic Association underpin the HCPC standards and the Nursing and Midwifery standards with more practical guidance. This Policy builds on the HCPC and BDA documents and standards and provides definitive local standards for the Trusts Dietetic and Nutrition Service. See Appendix 1 and 2 for details of these standards.

Entries must be made for every direct contact for inpatients and all patients on discharge, outpatients and day case patients, patients that did not attend clinic appointments, cancelled on day, structured education group, telephone consultation and telephone contact. The use of email to discuss patient care is discouraged.

The principles of good dietetic record keeping must be maintained in whatever format is used including manual health records, manual multi-professional records. There are different systems in use in different specialist areas

Table 1: IT Systems used by Dietetic and Nutrition Service Staff to Record care

System	**Specialist area**
ICE/Winscribe/Prescribe	Adult & Paediatric inpatient discharge and Adult Immunology, general adult
Dit3	Adult gastroenterology medicine, cancer surgery, bariatric surgery, immunology, allergy dietetic outpatients. All Paediatric outpatient clinic letters.
Eclipse	Adult Diabetes
Clinical Workstation	Adult & Paediatric Diabetes
Proton	Adult Renal
Badger	Neonatology
Somerset	Adult Cancer
eMEDS	Trust wide except for ITUs

Table 2: Processes detailed in relevant Appendices

Process	Appendix
Standards for Dietetic Record Keeping/Documentation	1
Minimum Standards for Nutrition & Dietetic Service Clinical/Documentation in main health care records, multidisciplinary and ITsystem based records	2
Minimum Standards for new patient documentation	3
Minimum standards for follow up patient documentation in Subjective Objective Assessment Plan, with change in care plan.	4
Minimum standards for electronic handover documentation	6
Use of ICE letters for discharge letters and outpatient clinic reports	7
Procedure for Electronic Medicines Prescribing Application (eMeds)	8
Procedure for Prescribing on Manual Critical Care Drug Charts (Oral Nutritional Supplements)	9
Procedure for Prescribing on Manual Pharmacy Drug Charts (Oral Nutritional Supplements & Enteral Feeds	10

Associated Documents – Service SOP for Dietitians use of Somerset

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All new Dietetic and Nutrition staff to the Trust will receive training on clinical Nutrition and Dietetic record keeping as part of their local induction programme. Training will be delivered by line managers within the Nutrition & Dietetic teams to ensure standardised training is provided.

6.2 All undergraduate student Dietitians on clinical placement will receive a practical skills based workshop on dietetic record keeping and documentation in week 1 of their induction of their clinical placement.

6.3 Dietetic and Nutrition Service staff are also recommended to attend the ‘ Healthcare Records by Trial’ training session run by National Centre of Rehabilitation Education (NCORE) subject to funding.

6.4 Alternatively Dietetic and Nutrition Service staff could request or be recommended by their line manager to attend a coroner’s inquest where record keeping is core to the process and evidence.

6.5 All new members of the staff need to read the Trust Records Management Policy (Trust Ref: B31/2005) as part of the local induction process.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Audit Frequency

Dietetic and Nutrition Service clinical records will be audited on an annual basis as part of the Trust wide Documentation audit against HCPC, BDA, NMC standards as required.

Dietetic and Nutrition Service letters on IT systems e.g. Dit3 and ICE will also be audited on an annual basis and reported through the CASE Audit summary report system.

7.2 Key audit standards

The following audit standards will be included as a minimum in the annual Documentation Audit for all staff groups, any additional audit criteria will be included on request:

a) All entries must be in black ink

b) All entries must be concise and easy to understand

c) All errors must be scored out with a single line and initialled or signed and dated with an explanation for their deletion

d) Any retrospective additions or amendments must be signed and dated with an explanation for their late inclusion.

e) Any retrospective alterations to electronic health records should be identifiable and reason for alteration explained

f) Correction fluid must not be used

g) Abbreviations should be avoided wherever possible and should only be used where an “approved abbreviation list” exists within specialties.

h) The patient’s full name and unique identifier number must be on every page

i) Staff entries must be clearly identifiable

• Identification is by using their signature and printed name

• Staff designation must also be stated

j) All entries must be dated and timed using the 24 hour clock

7.3 Audit Leads

Dietetic and Nutrition Service Head of Service and Clinical Dietetic Team Leaders have overall responsibility to ensure the audit is carried out. The audit could be completed by any clinical member of staff.

Self-assessment should be carried out and encouraged as part of registered practioners maintaining a Continuous Professional Development (CPD) portfolio for registration.

7.4 Audit reports need to meet the minimum requirements as detailed in the UHL

‘Documentation Audit Criteria and methodology’ and must include details of actions undertaken to improve compliance where indicated.

Audit results and action plans will be presented to the Clinical Audit Sub-group of the Quality and Safety Committee for the Clinical Support and Imaging Clinical Management Group.

Clinical Audit Committee who will refer on to the Clinical Effectiveness Committee if areas of concern are highlighted. Advice on the most effective methodology, both in terms of measuring the success of the document and using the minimum resources in doing so, can be sought from the Clinical Audit Team.

7.5 Audit Actions

Dietetic and Nutrition Service Head of Service and Clinical Dietetic Team Leaders are responsible for ensuring an action plan is developed that addresses any areas of non-compliance.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Health Care Professions Council. Standards of Proficiency Dietitians. 2013 London: HCPC.

Health Care Professions Council. Standards of conduct, performance and ethics 2016. London: HCPC.

Health & Care Professions Council Standards for Education and Training 2014, London: HCPC.

UHL NHS Trust Policy for Documenting in Patients Health Records (in all media) March 2011. (Trust Ref: B30/2006).

UHL NHS Record Management Policy, January 2013. (Trust Ref: B31/2005).

Dietetic Support Workers/Dietetic Assistants and Dietetic Assistant Practioners – roles, responsibilities and supervision requirements, September 2015. (Trust Ref: C33/2013).

The Code. Professional standards of practice and behaviour for nurses and midwifes. Nursing & Midwifery Council, March 2015

The British Dietetic Association website provides guidance to Dietitians on record keeping.

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be review 3 yearly by the authors of the document.

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of other professional groups**	**What tool will be used to monitor/check/** **observe/asses/** **inspect** **Authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report ?** **How often is the need to share the report?**	**How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements Who or what committee will the completed report go to.**
Standards as per Appendix 2	Nutrition & Dietetic Service Audit Leads	Nutrition & Dietetic Service Audit Tool	Annual	UHL Nutrition & Dietetic Service Dietetic Manager Business and Quality Safety Meeting
Standards as per Appendix 2	Nutrition & Dietetic Service Dietetic Managers	Review and approval of Datix incidents	Monthly	UHL Nutrition & Dietetic Service Dietetic Manager Business and Quality Safety Meeting

1. **Health & Care Professions Council Standards of Proficiency for Dietitians, March 2013**

That states in standard 10 that registrants must be able to maintain records appropriately and:

- Be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines
- Recognise the need to manage records and all other information in accordance with applicable legislation protocols and guidelines

2. **Health & Care Professions Council Standards of Conduct, Performance and Ethics, January 2016**

That states in standard 10 you must keep accurate records and ensure:

10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.

10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services.

10.3 You must keep records secure by protecting them from loss, damage or inappropriate access.

3. **Health & Care Professions Council Standards for Education and Training June 2017** which state that the curriculum and assessment must ensure that the student who completes the programme has met the standards of proficiency for their part of the Register.

4. **British Dietetic Association (BDA) Code of Professional Conduct, June 2008** which states under section 2.4 you should keep accurate records:

2.4.1 You should keep a written (and/or electronic) record of the intervention, advice given and the outcome of decisions taken.

2.4.1.1 Every service user should have a clearly recorded assessment of need and objectives of intervention.

2.4.2 Records should be accurate, legible, factual, in sequence, made promptly,and signed by the person who made them.

2.4.3 If you are delegating care activities to another member of staff appropriately (eg students, support workers) there must be a system in place to ensure the accuracy of the record, ie that what has been done has been accurately recorded. This may, but not necessarily, include countersigning for their entries. Until there is UK-wide national guidance on the countersigning of records by support workers and students the decision is one for individual departmental interpretation. The UHL NHS Trust Nutrition & Dietetic Service position is reflected in the Dietetic Support Workers/Dietetic Assistant

Practitioners – roles, responsibilities and supervision requirements (Trust Ref: C33/2013)

2.4.4 Subjective opinion should always be identified as such and should be clinical and relevant.

2.4.5 Records should be stored securely so as to be confidential.

5. British Dietetic Association Guidance for Dietitians for Records and Record Keeping, August 2008. This document provide detailed guidance on what is a record, purpose of the record, who owns the record, quality of the record, making a record including delegation and countersigning, responsibility of the organization, security , legal status of the record, information governance including consent, c onfidentiality and FAQ.

6. UHL NHS Trust Policy for Records Management Policy, March 2006(Trust Ref Document ID B31/2005).

7. UHS NHS Trust Policy for Documenting in Patients' Health Records (in all media), March 2011 (Trust Ref Document ID B30/2006).

8. Nutrition and Dietetic Service Standing Operating Procedure for the Management of Patient Records.

9. Nutrition and Dietetic Service Standing Operating Procedure for Somerset.

10. The Code Professional Standards of Professional Practice and Behaviour for Nurses and Midwives, The Nursing and Midwifery Council, 2015.

Clinical dietetic records should be maintained for everyone that is assessed and treated, asks for advice or asks for services whether provided or not including referrals declined. A clear record of all dietetic assessment, care, planning, monitoring and evaluation must be provided.

- The person who carries out the assessment, care planning, intervention and/or monitoring and evaluation should make the entry in the record.
- All entries must be chronological and contemporaneous, accurate, relevant, factual, objective and concise.
- All entries must be clear and legible
- All entries must not use slang, unexplained abbreviations and acronyms.
- All entries must use correct spelling
- All entries must be in black ink if manual
- Correction fluid must not be used in manual records
- All entries must be dated and timed using the 24 hour clock (inpatient's)
- All entries should also note the time of the intervention
- All entries must be signed and include the staff member's name written in block capitals and their designation. Eg , XXXX, C M STEELE, CLINICAL DIETETIC MANAGER/HEAD OF SERVICE
- Any retrospective additions or amendments must be signed and dated with an explanation for the late inclusion.
- All errors must be scored out with a single line and signed and dated with an explanation for the deletion
- All records should be written within 24 hours of contact with the patient or action related to patient care e.g. ordering of meals via catering
- If record not done within 24 hours then the transcribed entry should detail the date and time ithe notes were originally made. E.g.Entry made from notes made on 5.7.18 at 14.20.
- Records and patient related information should never be taken home unless absolutely unavoidable and should have a risk assessment carried out before hand by a Clinical Dietetic Manager as per UHL Trust Records Management Policy (Trust Ref: B10/2004)
- Records and patient related information if moved across UHL NHS Trust sites should have a risk assessment carried out before hand by a Clinical Dietetic Manager as per UHL Trust Records Management Policy (Trust Ref B31/2004).

- All records and patient related information must be kept securely and locked away at the end of the working day in line with local locking up procedures. A clean desk policy should be adopted by all dietetic staff.
- All regulations concerning the patients' access to records must be observed as per UHL NHS Record Management Policy (Trust Ref: B31/2005).
- All records and patient related information must be maintained and organized systematically. This is the responsibility of the Dietetic Support Team Leader.
- Always use a health care professionals colleague's full name and designation when referring to him/her in records e.g. Registered Staff Nurse, Cathy Steele
- Gaps must not be left in the record; any gaps should be scored through with a single line
- Patient's consent must be recorded in relation to treatment eg Skin Prick Tests in allergy outpatients, Blood Glucose Test as part of near patient testing in diabetes outpatients.
- Patient's consent must be recorded in relation to sharing of information e.g. school meals, nursery, nursing home, Nutricia Homeward.
- Abbreviations must be written in full in every entry. Then the abbreviation may be used for the length of that individual entry only.

Tracking of patients

All adult patients should have an electronic dietetic referral which will be undertaken by the referring wards. In areas such as intensive care units where blanket referrals are made then the ward dietitian can refer to themselves by completing the electronic dietetic referral "order".

The electronic dietetic referral can be used as a tracker of all inpatients referred and the standardised proforma (See Appendix 5) printed on the reverse of the referral should be completed on each dietetic review– e.g. feeding regimens or products prescribed. The patients on clinical Dietetic staffs caseload should be written on a dietetic tracker sheet with the follow up date on. Once the patient has been discharged, then the electronic dietetic referral and the dietetic tracker sheets will be shredded via confidential waste system on each base dietetic department. Any referral that has been made to the Leicestershire Partnership NHS Trust Home Enteral Nutrition Service (HENS), patients receiving enteral feeding in the community in Leicester, Leicestershire and Rutland and Community Hospital referrals via the Primary Care Dietetic Service or referral to other agencies, should be given to the dietetic admin staff for scanning and saving with the patient records on the UHL Tiara system. These are saved under 'external documents' on Tiara.

Documenting when medical notes are not available

It is recognized that health care records may not be available on some occasions after an indirect patient consultation. For example, a discussion with a Home Enteral Service Dietitian may take place over the telephone. In this situation, it is recommended that a note is kept with a time and date that the discussion took place and then at the next

available opportunity that this dialogue is retrospectively documented in the patients' medical notes.

It is likely that dietetic staff will find that some office based activities such as telephone calls about inpatients may be best done in a ward environment when there is access to the patient case notes for documentation purposes.

NOTE

- Registered Dietitians must be satisfied that any Dietetic Assistant staff and Dietetic undergraduate students to whom a task is delegated by them is competent to carry out the intervention and the recording of it. They need to take appropriate steps to ensure the accuracy and appropriateness of the record made by others under their supervision.
- See separate Clinical Guideline (Trust Ref: C33/2015) regarding the roles, responsibilities and supervision requirements for Dietetic Support Workers/Dietetic Assistants and Dietetic Assistant Practioners.
- All student dietetic entries must be countersigned in the health care record by the supervising Dietitian in line with UHL Documentation Policy for Patient's Case Notes (Trust Ref: B30/2006). This includes medical note, nursing and bed end chart entries. Student dietitians should not make entries on drug charts.

The details of this assessment will be recorded in full in the medical case notes/on IT system. A concise log of actions will be recorded on the patients' electronic referral only.

The intial assessment must be completed by the patients named Dietitian or Dietetic Assistant Practioner.

Date

Time (24 hour clock for inpatient)

Dietitian Name

State referral when made and when received: dates, by whom (name/designation), how (verbal/ICM/medical case note entry/ward round), and reason for referral (ie MUST score/enteral feeding)

Intial Interview

Noted: Relevant Past Medical History, History of Present Conditions and Diagnosis and Social circumstances.

Initial Assessment

Assessment in ABCDE format and may include the following points

Anthropometry: Weight/Height/Body Mass Index (BMI) (using metric)
Weight loss (kg and %) Nb related to time period
Upper arm anthropometry where used

Biochemistry: Make note of any relevant biochemistry

Clinical

Information on relevant medical conditions

Factors affecting dietary intake

Current situation i.e. Temperature, Bowels, Vomiting, Diarrhoea

Type of tube and insertion date

Dietary and Drugs

Intake from 24 hour recall/food charts – “from nutritional assessment this inpatient is currently managing xx kcals / day and xx grams protein / day from oral food and fluids

Relevant drugs from drug chart/epma system

Estimated Requirements

State basal metabolic rate plus any additions for total energy expenditure, nitrogen ranges, fluid mls/kg as a minimum (info intended for dietitians reviewing patient)

Above should reflect subjective information including information from the patient and / or carers including their views and information from the multi-disciplinary teams eg Medical, Nursing, SALT, Pharmacist, Specialist Nurse.

Subjective information eg from nutritional assessment this inpatient is currently managing xx kcals/day and xx grams Protein/day from oral food and fluids .

Objective information including clinical observations. Summarise objective information using the ABC method:-

Aims/goals/review of aims or goals

Following an initial interview and assessment the treatment plan/ goals should be discussed and agreed with the patient. This should be shared with the multidisciplinary team.

Goals must be 'SMART': Specific, Measurable, Achievable, Relevant and Timely.

Treatment plans

All Dietetic plans made with, or on behalf of, the patient must be recorded in the health care records. This may also include:

- Patient response to intervention and progress towards achieving goals
- Modification of goals as required to meet patient's response and need
- Identified needs which dietitian cannot meet, and action taken
- Reasons for non-achievement of goals
- References to other relevant information
- Communications relating to patient's on-going treatment and discharge plans
- Patient's and/or carer's views
- Liaison with/referral to other professionals/agencies
- Refusal of treatment or non-attendance including explanation

Aim for example:

To meet deficit between nutritional requirements and nutritional intake recommend:

Also document; Identified needs which Dietitian cannot meet and action taken. Patients and/or carer's view. Liaison with other professional/agencies. Refusal of treatment or non-attendance including explanation.

E.g

Plan: to include

Intervention eg

Intervention - Fortisip 200mls bd providing an additional 600kcals and 24 grams of protein per day – prescribed on drug chart ward nursing staff to give patient

Intervention - Calogen 30mls tds providing an additional 400 kcals per day – prescribed on drug chart ward nursing staff to give patient

Monitoring eg

Monitoring – Daily food record charts to be completed by ward nursing staff for dietitian to use for ongoing assessment of oral nutritional intake

Monitoring – Weigh patient twice weekly by ward nursing staff for dietitian to use for ongoing assessment of nutritional status

Plan should reflect clinical reasoning and professional option

Follow up by whom (Dietitian/Dietetic Assistant/Other) and when planned

Signature,

Print name & Designation

Bleep/Pager number

Date

Time (24 hour clock for inpatient)

Dietitian Name

Subjective Objective Assessment Plan entry

Subjective e.g. from food record charts dated xx and xx in last two days patient managing 600 kcals and 10 g protein per day.

Objective e.g. further weight loss from 60 kg to 58 kg in 1 week

Poor appetite - patient reports this is due to nausea – I note anti emetics have commenced today

Biochemistry noted – phosphate remains low at 0.5 mmol/l on xx date

Assessment current nutritional intake is meeting approximately 30% of energy daily requirements and 20% of protein daily requirements

Plan nursing staff to continue to monitor oral intake on food chart for assessment

Doctors to consider phosphate supplementation

Encourage intake and oral nutritional supplements prescribed – Fortisip 200ml bd and calogen 30 mls tds providing an additional 600 kcals and protein and kcals respectively per day on top of food intake

High calorie/protein food based advice given to patient and relatives.

Dietetic Assistant will review in one week – please contact me on the bleep below in the meantime if further concerns arise

Signature, Print name, Designation and Bleep/Pager

Example of REVIEW patient documentation with no change in care plan

Date, Time (24 hour clock for inpatient)

Dietitian / Dietetic Assistant: Print name, Designation and Bleep/Pager

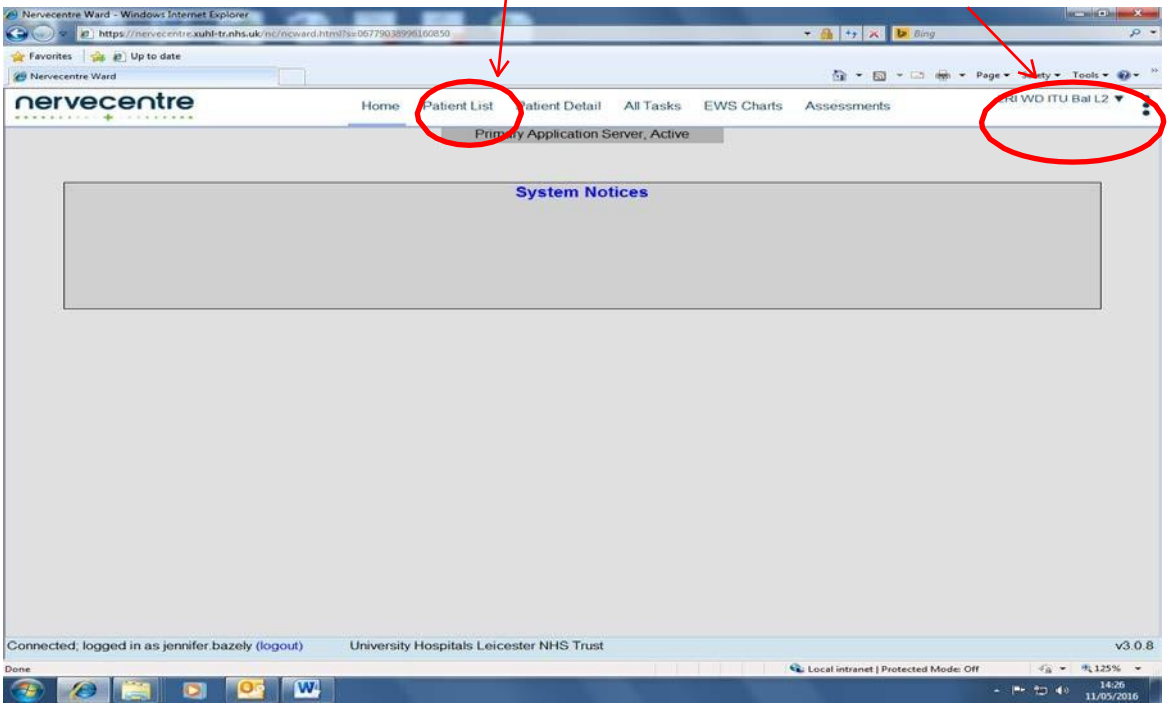
The use of the electronic handover does not replace verbal handover to relevant clinical staff at ward level. It can be used to assist in care planning and discharge facilitating to ensure dietetic treatment plan communicated as appropriate. Electronic handovers should not be used as a sole dietetic record and full assessment and treatment plan should always be documented in medical notes in a timely manner.

It is recommended dietitians limit documentation to 'Nutritional Status' and 'Specialty Info' boxes as these are common across nursing and medical handovers. Those within extended role's may wish to add dose adjustments of medication to 'Specialty info' box on electronic handover.

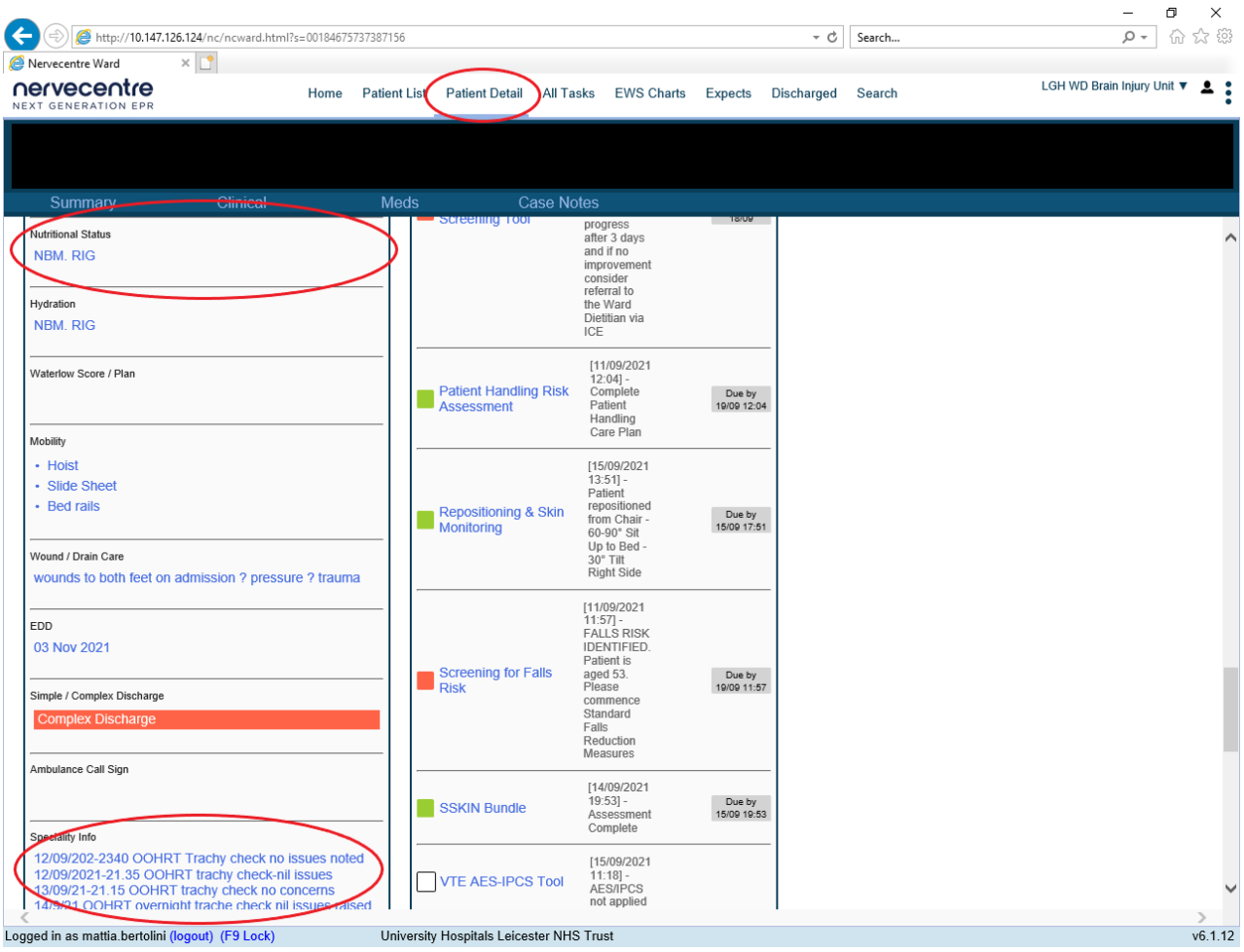
Examples of use of electronic handovers include;

- Route of feeding; enteral (Nasogastric feeding, gastrectomy, jejunostomy and others), parenteral nutrition, oral diet or Nil by Mouth status.
- Input from associated services e.g. Home Enteral Nutrition Service (HENS) training and plans for this (dates and times could be included). If patient not to be seen until discharge home by HENS this could be stated in 'Specialty info' on handover.
- Dose adjustment and titration of Phosphate binders, insulin dosage and Pancreatic Enzyme Replacement Therapy (PERT) adjustments by extended role dietitians.
- If the nutritional care plan has not be implemented (e.g. food charts not completed and weights not recorded) then this can be added to electronic handover under 'Nutritional status'.

Chose the ward list you would like to amend. Click on the down arrow to change the location and select the correct ward / unit. Then click on ‘Patient List’.



Double click on the patient you would like to view / amend. Please note you should use the nurse handover and use the ‘Nutritional Status’ box or ‘Speciality Info’ box. Both of these boxesare present on the nurse and doctor handovers.



Once an inpatient intervention is complete or a patient has been seen in the outpatient setting an ICE discharge letter should be created. The letter should be sent within 3 days of inpatient discharge or within 7 days of the outpatient clinic. If these targets are exceeded significantly a rationale for this must be provided and a clinical risk assessment undertaken. The letter should be sent electronically and another manual copy put in the post. The letter should be copied to the patient as well routinely.

Using the ICE letter standard template for Nutrition & Dietetics the following information must be included:

1. Patient demographics to include: (this information is generally pre-populated by the ICE system).
    a. Patients name
    b. Address
    c. Appointment and/or discharge date (outpatients).
    d. Admission date and discharge date (inpatients)
    e. Gender
    f. DOB
    g. NHS number
    h. Hospital number
2. Date of clinic (if outpatient) can also include date of telephone review if appropriate.
3. Speciality/members of department – use drop down menu to select appropriate team & address
4. Diagnosis
    a. Clinical and/or nutritional diagnosis (Taken from medical discharge letter)
5. Anthropometrics
    a. Weight (with date recorded if information available)
    b. Height/length
    c. BMI – add comment low, normal, raised
    d. Centiles for height & weight, if appropriate
    e. Percentage weight loss, if appropriate
    f. Any other anthropometry e.g. MAC/TSF
6. Information for patient/carer
    a. Use drop-down menu where appropriate to reiterate advice given

b. Name any diet sheets sent to patient e.g. Food First diet sheet

7. Clinic notes/comments
    a. Optional section to include any specific advice or target/outcome set e.g target BMI
8. Progress report
    a. Optional section useful for comments from a patient review.
    b. To use Nutrition and Dietetic Service Reference Guide to LMSG Managing Malnutrition in Adults in Primary care for standardised statements.
9. Oral supplement to be prescribed MUST include (use the ICE letter template document where possible)
    a. Product name
    b. Flavour
    c. Volume of individual supplement and the total volume of supplement required to be prescribed for the following 28 days. E.g, Fortisip Compact tds, 125ml x 3 daily, therefore 28 day supply of 10,500ml required.
    d. Frequency
10. Indication for product requested (use the ICE letter template document where possible)
    a. Include ACBS criteria
    b. Include any other clinical reasoning e.g disease related malnutrition as evidenced by 20% weight loss, wound healing, MUST score
11. Action requested of GP (use the ICE letter template document where possible)
    a. Include expected duration of prescription request – typically 28 days, if longer prescription required give a rationale
    b. Be clear if/when ONS to be stopped
    c. Can use this section to request GP referral to other provider, if necessary
12. Follow-up plans (use the ICE letter template document where possible)
    a. Who will review the patient e.g GP, Dietitian, UHL, LPT, Primary Care
    b. When will patient be reviewed
    c. State clearly if patient is being discharged from the service and if anyone else will be responsible for monitoring.
13. Patient has been discharged as (use the ICE letter template document where possible)
    a. Standard sentence of 'The above patient has now been discharged from the UHL Nutrition and Dietetic service'.
14. Signature
    a. Include name and designation (as documented on your email e.g Dietitian)
15. cc: list

a. MUST include ‘patient’ unless contraindicated

b. Can include other relevant parties e.g. GP, referring Consultant, HENS.

Online training for usage of eMeds is provided on HELM and Dietitians are requested to complete the training for Prescriber's. Full access is provided once online training has been completed.

Dietitians can prescribe the same enteral feeds and oral nutritional supplements on eMeds as they can on paper drug charts.

Once logged into Nervecentre, search for the patient, and confirm you have selected the correct patient before entering their electronic drug chart. Double click on the patients name and then click on 'Meds' to enter the drug chart.

The use of electronic prescribing various across specialties but in principal should be used to prescribe The Advisory Committee on Borderline Substances (ACBS) approved nutritional products. Those with extended roles as stated above can modify doses using this system as appropriate.

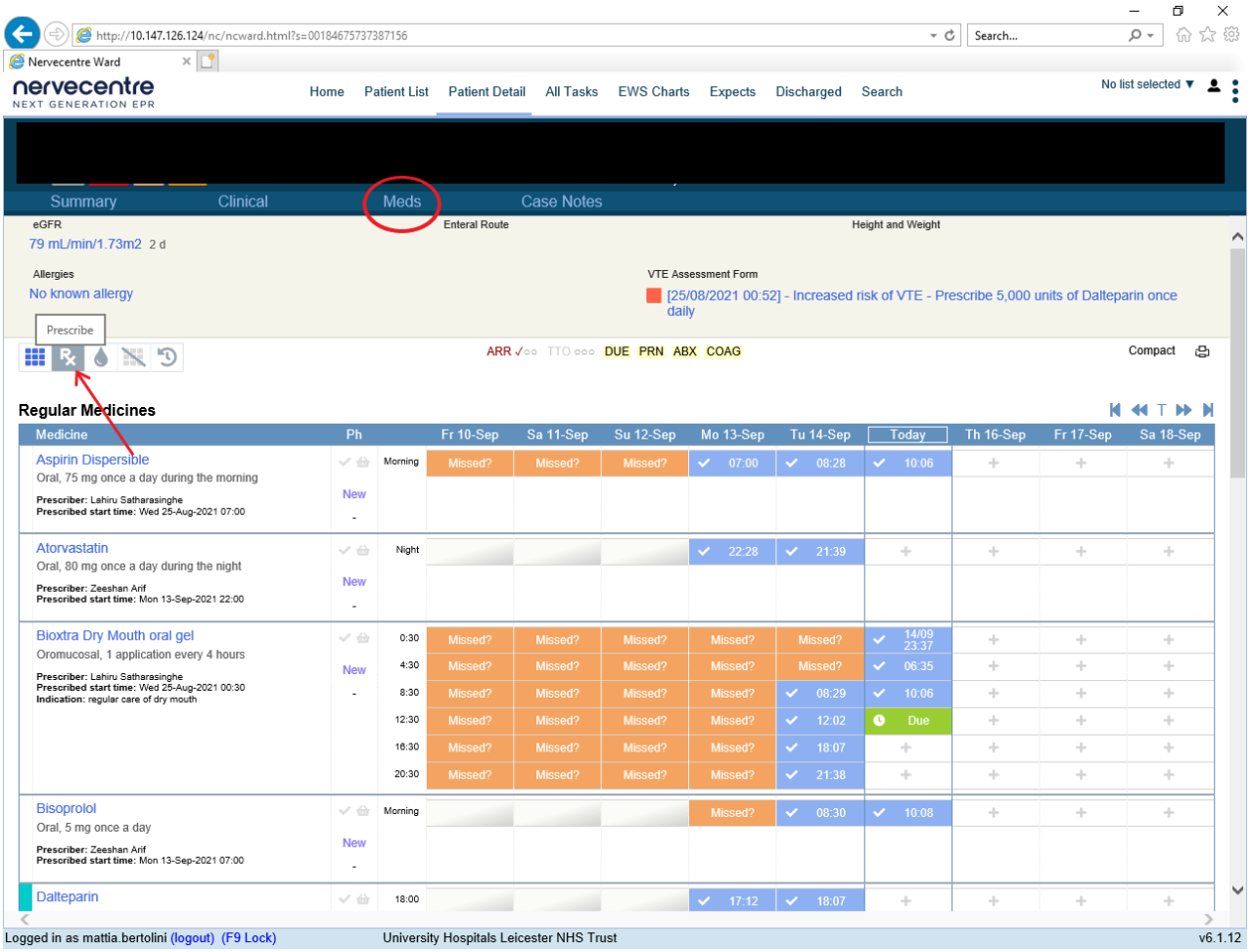
The medical management of refeeding syndrome, e.g. prescription of Thiamine/Vitamin B Co-strong or Pabrinex should be prescribed by the medical team.

The dose and timing of all nutritional products should be clearly stated.

Request for to take out (TTO) medication can also be placed on electronic prescribing systems to facilitate patient discharge.

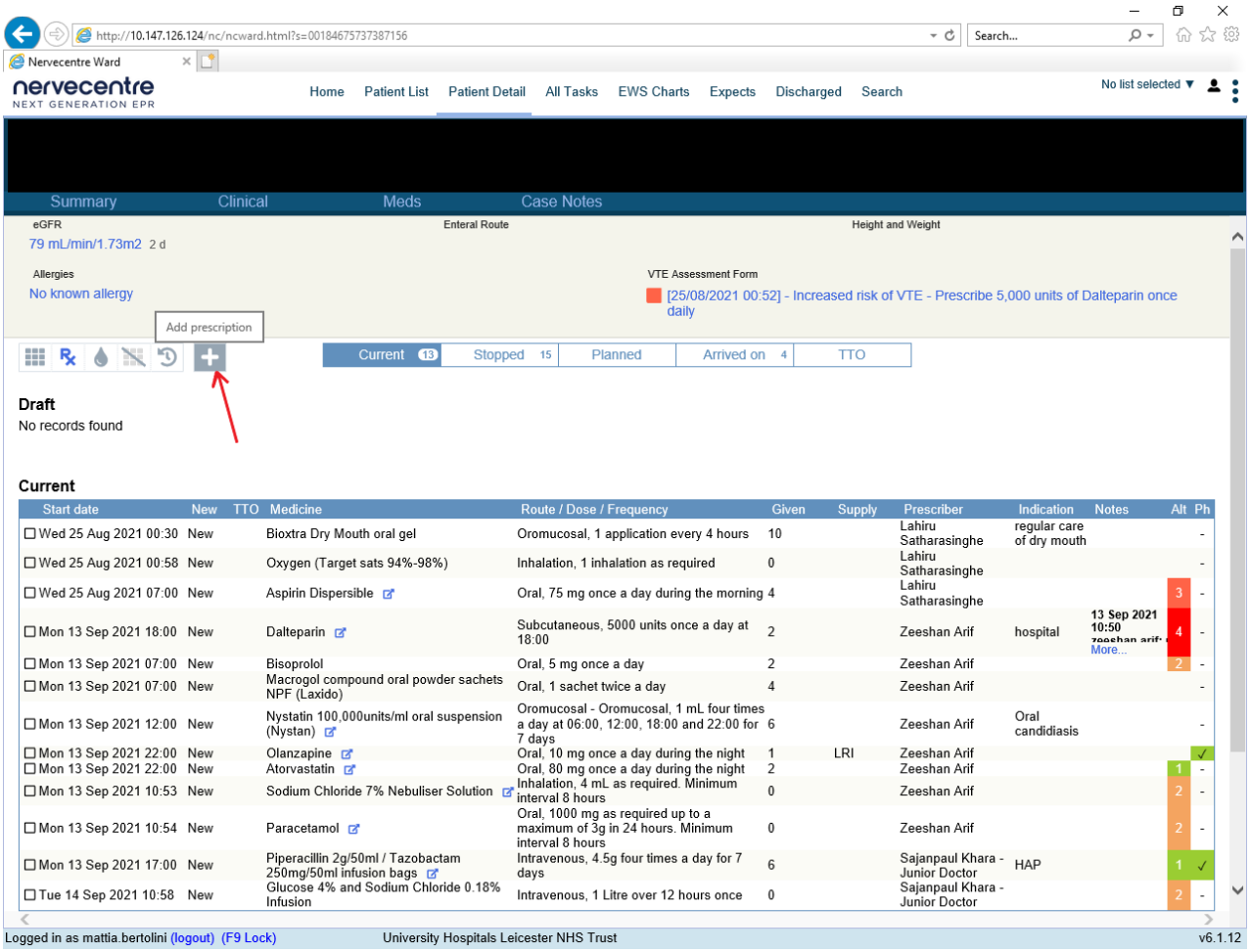
Search for the selected patient using identifier number and from the ‘Patient detail’ menu click on ‘Meds’ to enter the drug chart.

The drug chart will show as follows:

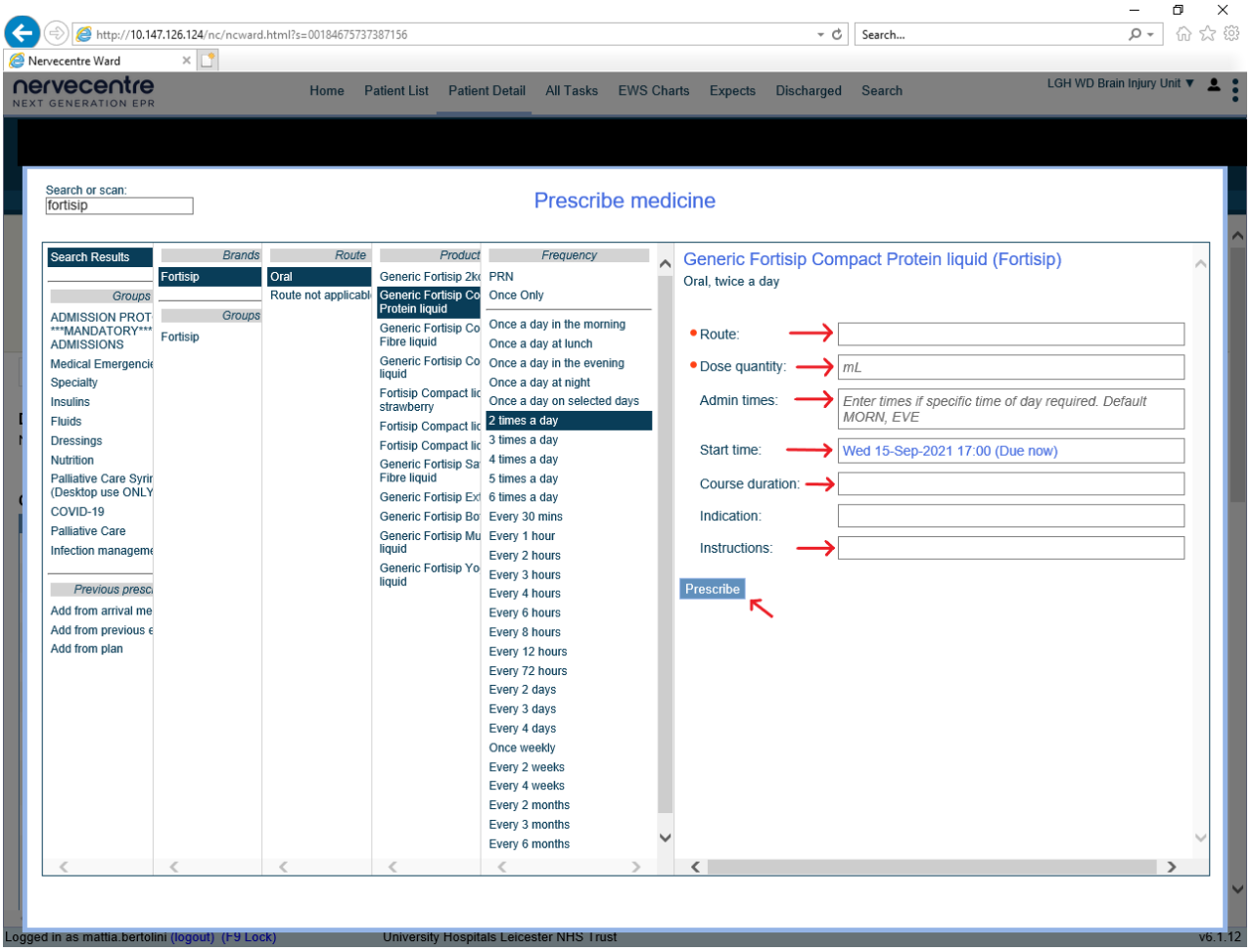


Click on ‘RX’ to add/cease any medications.

Click on '+' to add new medications.

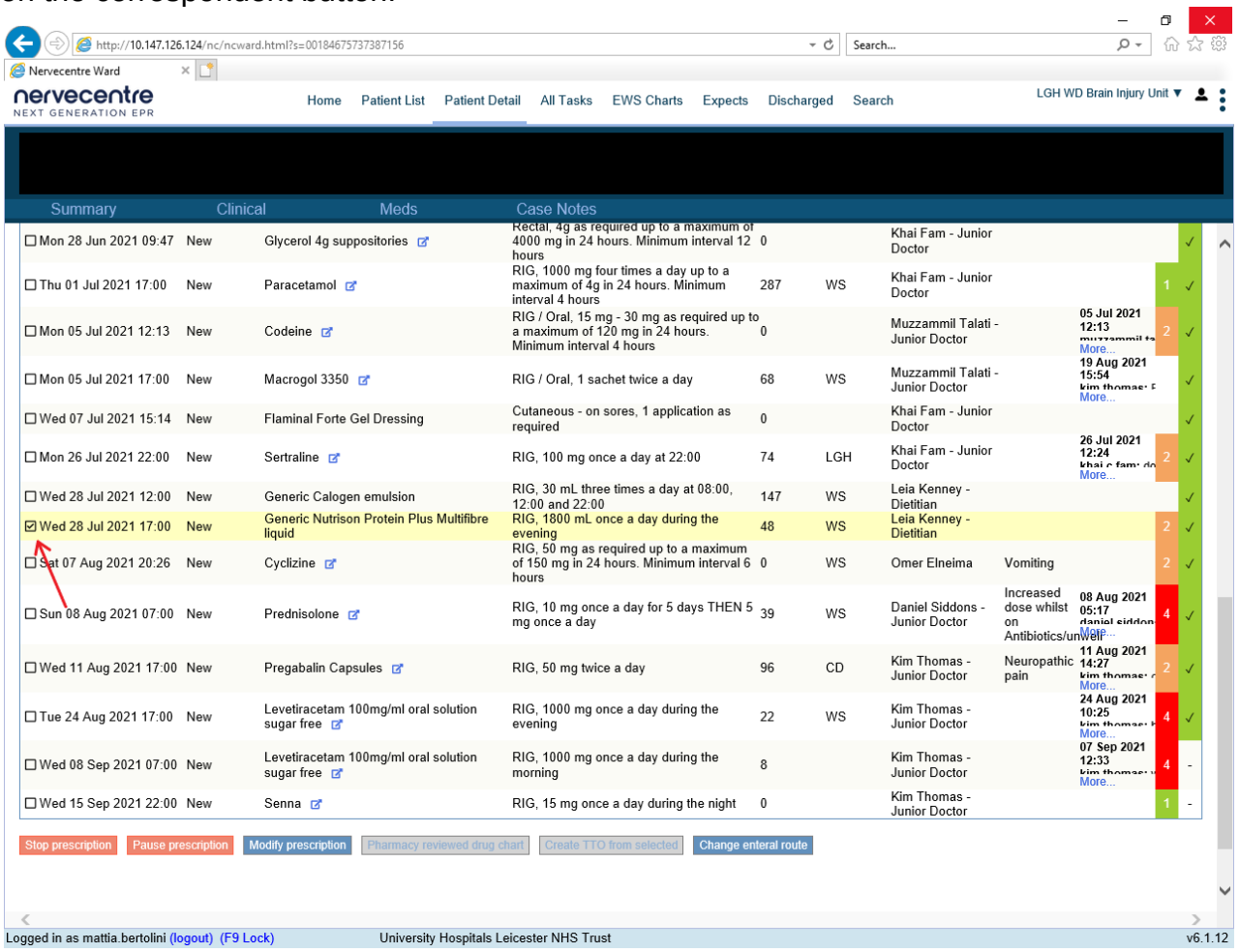


Search for the medications to prescribe and select the appropriate one as shown below.

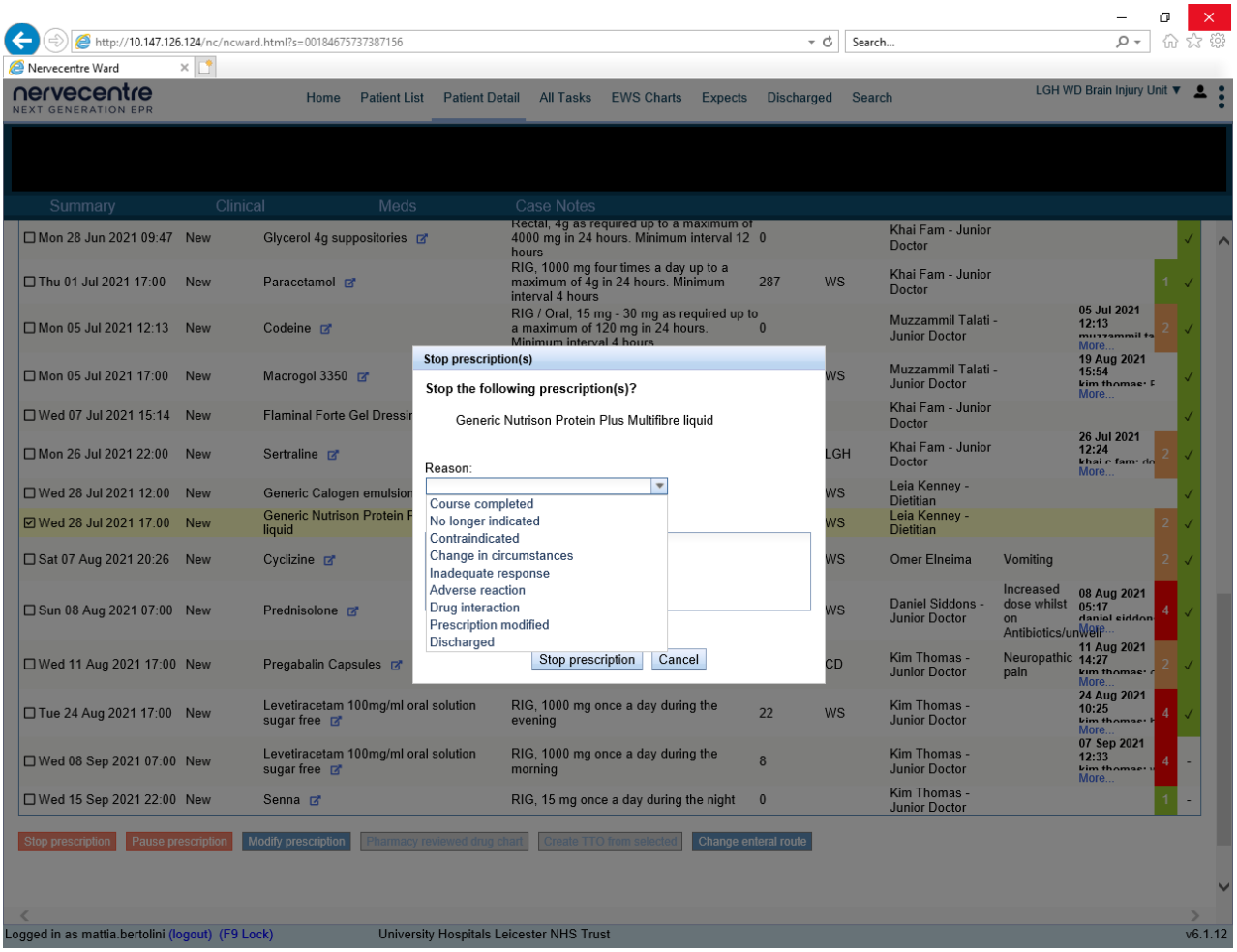


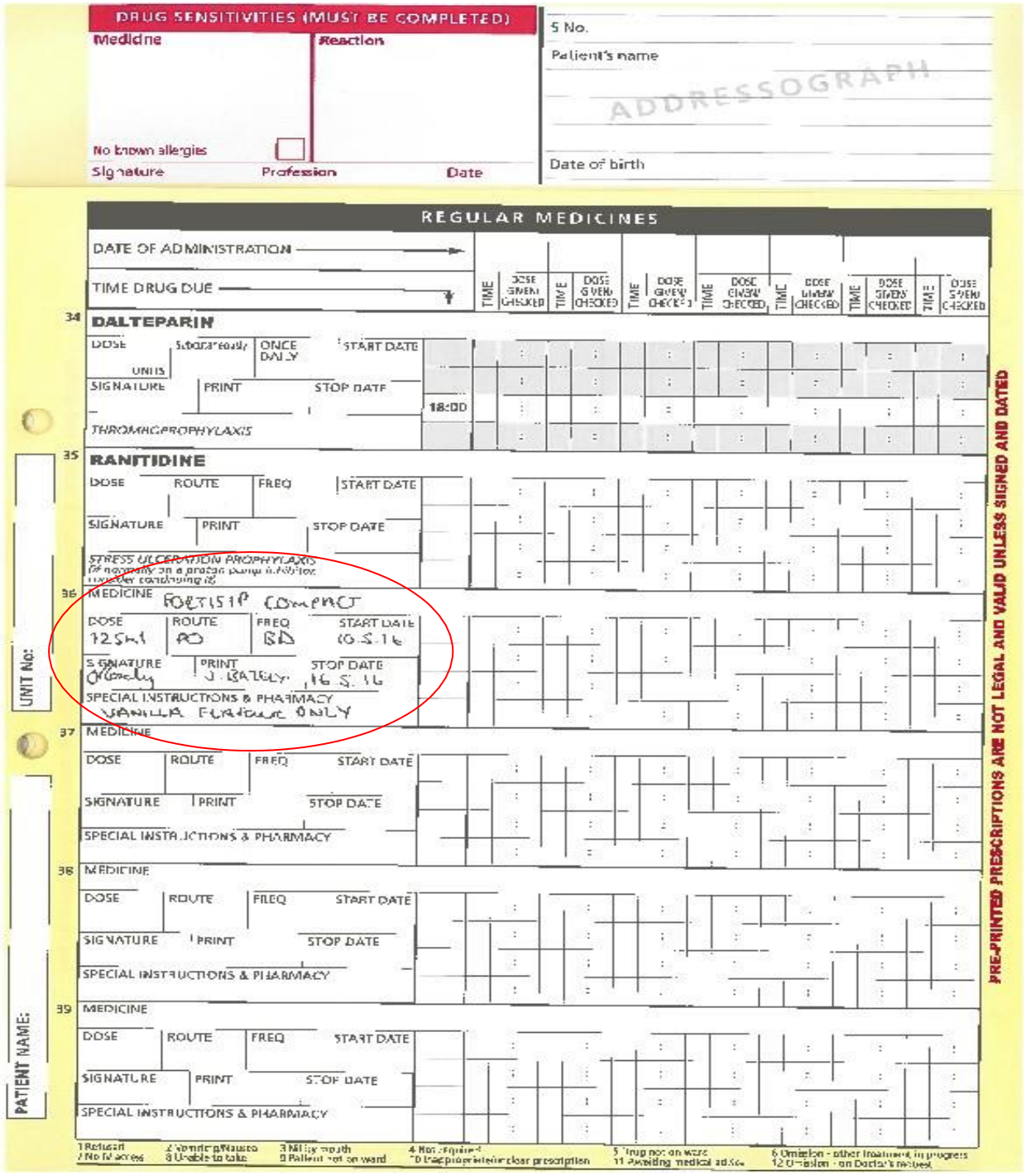
Choose the appropriate supplement / feed, frequency, route (if applicable), dose, timings, course duration (if applicable). Add further instructions if needed. Then press ‘Prescribe’.

To remove any prescriptions from the drug chart, tick the appropriate box and press ‘Stop prescription’. You can also: pause the prescription and/or modify the prescription, clicking on the correspondent button.



You will be asked for confirmation that this is the medication you would like to remove from the drug chart. Please select the reason why you want to stop the current prescription from the dropdown menu. Then click ‘Stop prescription’.





DRUG SENSITIVITIES (MUST BE COMPLETED)
Medicine | Reaction
No known allergies
Signature | Profession | Date

S No.
Patient's name
ADDRESSOGRAPH
Date of birth

REGULAR MEDICINES
DATE OF ADMINISTRATION
TIME DRUG DUE
TIME | DOSE GIVEN CHECKED

34 DALTEPARIN
DOSE | UNITS | Subcutaneously | ONCE DAILY | START DATE
SIGNATURE | PRINT | STOP DATE
18:00
THROMBOPROPHYLAXIS

35 RANITIDINE
DOSE | ROUTE | FREQ | START DATE
SIGNATURE | PRINT | STOP DATE
STRESS ULCERATION PROPHYLAXIS

36 MEDICINE FORTISIP COMPACT
DOSE 125ml | ROUTE PO | FREQ BD | START DATE 10.5.16
SIGNATURE | PRINT J. BAILEY | STOP DATE 16.5.16
SPECIAL INSTRUCTIONS & PHARMACY VANILLA FLAVOUR ONLY

37 MEDICINE
DOSE | ROUTE | FREQ | START DATE
SIGNATURE | PRINT | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY

38 MEDICINE
DOSE | ROUTE | FREQ | START DATE
SIGNATURE | PRINT | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY

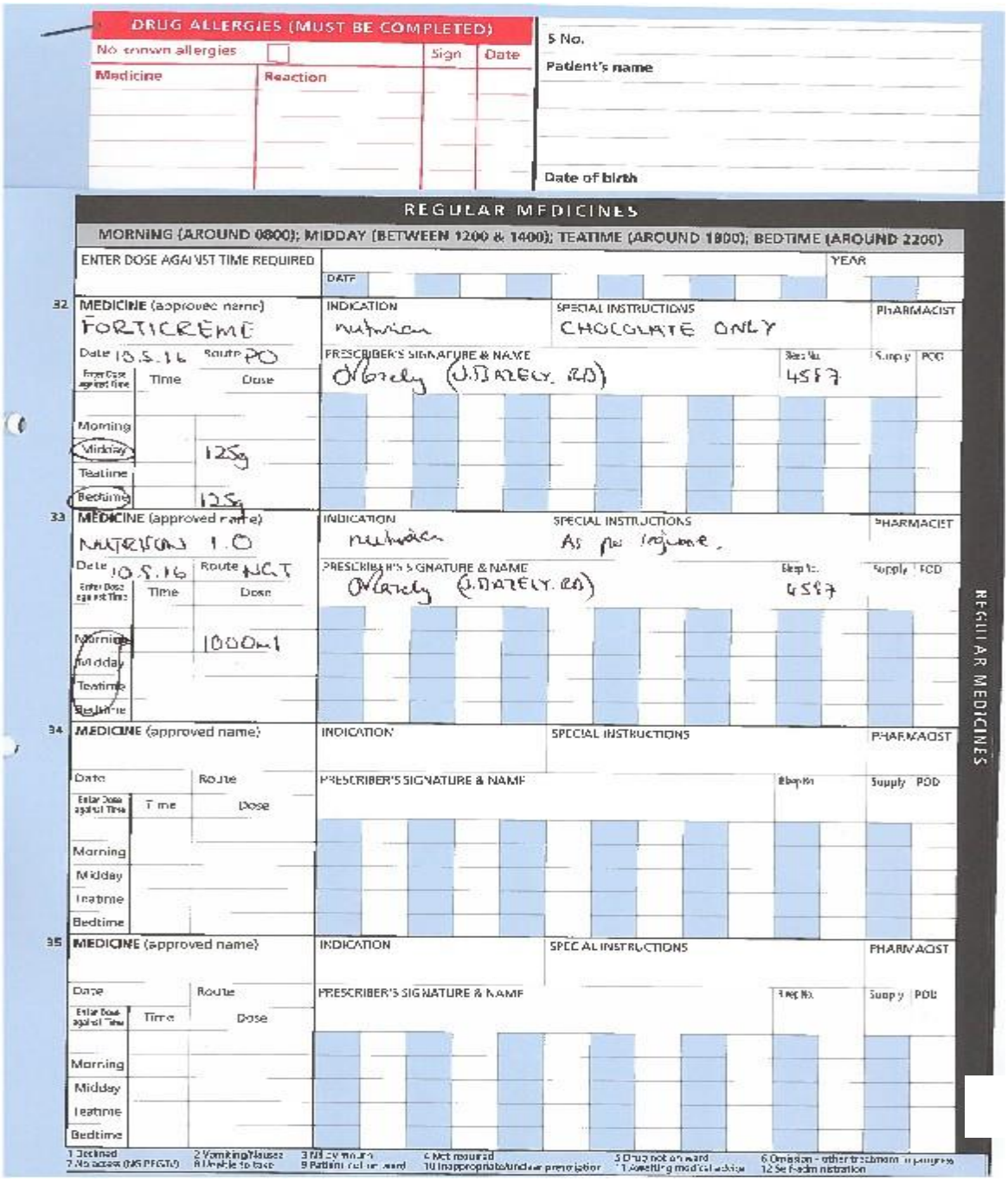
39 MEDICINE
DOSE | ROUTE | FREQ | START DATE
SIGNATURE | PRINT | STOP DATE
SPECIAL INSTRUCTIONS & PHARMACY

1 Refused / No IV access | 2 Vomiting/Nausea | 3 Nil by mouth | 4 Not required | 5 Drug not on ward | 6 Omission - other treatment in progress
8 Unable to take | 9 Patient not on ward | 10 Inappropriate/unclear prescription | 11 Awaiting medical advice | 12 Omission - on Doctor's request

PRE-PRINTED PRESCRIPTIONS ARE NOT LEGAL AND VALID UNLESS SIGNED AND DATED

UNIT No:

PATIENT NAME:


DRUG ALLERGIES (MUST BE COMPLETED)
No known allergies
Medicine
Reaction
Sign
Date
S No.
Patient's name
Date of birth
REGULAR MEDICINES
MORNING (AROUND 0800); MIDDAY (BETWEEN 1200 & 1400); TEATIME (AROUND 1800); BEDTIME (AROUND 2200)
ENTER DOSE AGAINST TIME REQUIRED
DATE
YEAR
32 MEDICINE (approved name)
FORTICREME
INDICATION
nutrition
SPECIAL INSTRUCTIONS
CHOCOLATE ONLY
PHARMACIST
Date 10.5.16
Route PO
PRESCRIBER'S SIGNATURE & NAME
O'Grady (J. O'GRADY. RD)
4587
Supply
POD
Enter Dose against Time
Time
Dose
Morning
Midday
Teatime
Bedtime
125g
125g
33 MEDICINE (approved name)
NUTRISON 1.0
INDICATION
nutrition
SPECIAL INSTRUCTIONS
As per request.
PHARMACIST
Date 10.5.16
Route NGT
PRESCRIBER'S SIGNATURE & NAME
O'Grady (J. O'GRADY. RD)
4587
Supply
POD
Morning
Midday
Teatime
Bedtime
1000ml
34 MEDICINE (approved name)
INDICATION
SPECIAL INSTRUCTIONS
PHARMACIST
Date
Route
PRESCRIBER'S SIGNATURE & NAME
Supply
POD
Enter Dose against Time
Time
Dose
Morning
Midday
Teatime
Bedtime
35 MEDICINE (approved name)
INDICATION
SPECIAL INSTRUCTIONS
PHARMACIST
Date
Route
PRESCRIBER'S SIGNATURE & NAME
Supply
POD
Enter Dose against Time
Time
Dose
Morning
Midday
Teatime
Bedtime
1 Declined
2 Vomiting/Nausea
3
4 Not required
5 Drug not on ward
6 Omission - other treatment in progress
7 Awaiting medical review
8 Unable to take
9 Patient not on ward
10 Inappropriate/unclear prescription
12 Self-administration
REGULAR MEDICINES