Long-Term Care Charting Guidelines

Regulations require that a registered dietitian (RD) complete a nutritional assessment on:

- each new resident upon admission
- any resident having a significant change in diet, eating ability, or nutritional status
- a monthly basis for any resident receiving tube feedings
- an annual basis

You must also chart on residents quarterly and upon discharge unless the dietary manager completes these notes.

Admission Nutritional Assessment

The admission nutritional assessment establishes a baseline and goals for overall nutrition care. It should include whether the resident is malnourished, at risk of malnourishment, or if nutritional status appears adequate. Determine nutritional status through tools such as the mini-nutritional assessment, direct observation and communication with the resident, as well as communication with staff members. Using the information that you gathered, you can then support your judgement. Complete this assessment within 14 days of a new admission.

> **Example documentation:**
> *91 y/o F. Nutrition Status Score: at risk of malnutrition. Resident was admitted 4/3/19 for therapy and strengthening following hospitalization for hip repair following fall at home. Resident has a past medical hx of T2DM, COPD, HTN, CVD, depression, and breast CA (1997). Medications that affect nutrition and hydration status include atorvastatin (anorexia), citalopram (anorexia, xerostomia), lisinopril (diarrhea, xerostomia), metformin (diarrhea, weight loss), omeprazole (diarrhea, nausea), polyethylene glycol (dehydration), and simvastatin (constipation). Resident is on a regular diet consuming 50-75% at meals. Resident has full dentures, is independent at meals, and reports no issues chewing or swallowing. Resident's BMI is 27.8, which is appropriate for age and health status. Per resident and family interview, resident's UBW is 165 lbs. and resident has not experienced any weight loss or gain x3 mo. Skin is intact, however, resident is at risk of pressure ulcers due to limited mobility. RD to follow and intervene as indicated. RD signature*

Quarterly Nutrition Note

The quarterly nutrition note is done every three months and supports minimum data set (MDS) documentation and care plan decisions. It identifies whether you're meeting the resident's care plan goals. Document how the resident is progressing, if goals are being met, and if the interventions in place are working. Don't repeat, but summarize, all the data gathered.

Example documentation:
See admission nutritional assessment (date) for hx. Resident was at appropriate BMI for age and health status and maintained her UBW of 165#. Resident is likely meeting nutritional needs with current PO intakes of 75-100%. Skin remains free of pressure ulcers. Care plan remains relevant. Continue POC.
RD signature

Significant Change Nutrition Note

The significant change nutrition note documents changes for either improvements or decline of a resident's status that may affect their nutritional status. A significant change includes a change in diet or diet texture, weight, eating ability, transition to tube feeding or hospice, and/or a change in health status or medications.

Example documentation:
Resident's diet texture was changed from regular to soft and bite sized per SLP evaluation and recommendation r/t resident's advancing dementia. PO intake prior to texture modification was 25-50%. Wt has trended down since admission (5.6% x2 mo.). RD to follow and monitor changes in PO intakes related to diet texture change. Care plan reviewed and updated.
RD signature

Tube Feeding Nutrition Note

The tube feeding nutrition note is done monthly and must include the feedings nutritional adequacy of calories, protein, and fluids. Review stools, tube feeding tolerance, and recent labs, specifically the electrolytes.

Example documentation:
Resident receives alternate form of nutrition and hydration d/t dysphagia secondary to CVA as recommended by SLP. Resident receives continuous 12 hr nocturnal feeds of Jevity 1.2 Cal at 135 mL/hr through PEG tube, which provides 1944 kcals, 90 grams PRO, 274 grams CHO, 68 grams FAT, and 1307 mL of free water, providing 135% of the RDI for micronutrients. Resident receives additional 200 mL free water boluses TID, bringing total fluid intake to 1907 mL per day. Resident is meeting nutritional needs through current feeding. Labs from 3/14/19 are WNL. Per interview with resident and nurse, stool frequency is 1-2 per day, and resident is tolerating feeding well.
RD signature

Annual Nutritional Assessment

The annual nutrition assessment establishes a new baseline and goals for overall care. It's similar to the initial nutritional assessment and should follow the same documentation format. Review and update the care plan as necessary.

In-Between Nutrition Note

In-between nutrition notes occur between the required charting times. Instances that warrant an in-between nutrition note include specific observations, referrals, eating changes, wounds, and weight changes.

Example documentation:

Resident has experienced significant wt loss of 12 lbs. (7.3% x1 mo.), likely due to inadequate PO intakes averaging 25-50%. Per interview with nurse, resident has been eating in her room and refusing several meals. Resident notes her appetite has declined and she has lost interest in social activities. RD notified IDT of recent wt loss and RD's interventions of encouraging resident to dine in common area, offering an alternative meal if PO intakes < 50%, and providing high-protein, high-calorie snacks between meals. These interventions will be monitored and evaluated for effectiveness and revised as appropriate.

RD signature

Discharge Nutrition Note

The discharge nutrition note summarizes a resident's nutritional status during stay. Note any nutrition education needs you may have identified and whether you provided that education prior to discharge. Update the care plan as necessary for continuation of care.

Example documentation:

Resident admitted 3/5/19 for strengthening following hospitalization for intracapsular fracture secondary to fall. Resident was underweight for age and health status but experienced no significant wt loss during stay and maintained adequate nutrition and hydration status. Resident is set to d/c home 4/5/19. Provided verbal and written instruction on high-protein, high-calorie foods, and meal ideas prior to d/c.

RD signature

Summary of charting guidelines

Event	Reason	Key Points
Admission	To establish a baseline and goals for overall nutrition care within 14 days of admission.	• Identify nutritional status and factors that may increase nutrition risk.
Quarterly	Supports minimum data set (MDS) documentation and care plan decisions. Usually completed by dietary manager.	• Identify whether the nutrition care plan goals are being met.
Significant change	To documents changes for either improvements or decline that may affect nutritional status. Complete as needed.	• Identify the significant change and how it may affect nutritional status.
Tube feeding	To ensure toleration and nutritional adequacy of tube feeding. Complete monthly.	• Review tube feeding tolerance, labs, and nutritional adequacy.
Annual	To establish a new baseline and goals for overall nutrition care. Complete annually.	• Identify nutritional status and factors that may increase nutrition risk.
In-between	To document changes between the required charting times. Complete as needed.	• Document referrals, wounds, weight and eating changes.
Discharge	To provide a continuity of care and assess for education needs. Commonly completed by dietary manager.	• Provide education and update care plan if indicated.