

# The Nutrition Care Process and Model – FAQs

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## General NCP Questions

1. What is the Nutrition Care Model?

The Nutrition Care Model is a graphic visualization that illustrates the steps of the Nutrition Care Process (NCP) as well as internal and external factors that impact application of the NCP. The central component of the Model is the relationship of the target patient/client, client, or group and the RD. One of two outer rings represents the skills and abilities of the RD along with application of evidence-based practice, application of the Code of Ethics, and knowledge of the RD. The second of two outer rings represents environmental factors such as healthcare systems, socioeconomic, and practice setting that impacts the ability of the target group or client to benefit from RD services. Screening and referral and outcomes management are also components of the model (and are discussed later in this series of questions).
2. What is the Nutrition Care Process?

The NCP is a systematic approach to providing high quality nutrition care. It was published as part of the Nutrition Care Model. Use of the NCP does not mean that all patients/clients (defined in question below) get the same care. Use of a care process provides a framework for the RD to individualize care, taking into account the patient/client's needs and values and using the best evidence available to make decisions. Other disciplines in healthcare, including nurses, physical therapists and occupational therapists have adopted care processes specific to their discipline. In 2003, the House of Delegates (HOD) of the American Dietetic Association (ADA) (now the Academy of Nutrition and Dietetics) adopted the NCP in an effort to provide dietetics professionals with a framework for critical thinking and decision-making. Use of the NCP can lead to more efficient and effective care and greater recognition of the role of dietetic professionals in all care settings.
3. What does "patient/client(s)" refer to?

The terms **patient(s)/client(s)** are used in association with the NCP; however, the process is also intended for use with groups. In addition, family members or caregivers are an essential asset to the patient/client and food and nutrition professional in the NCP. Therefore, groups, populations, families, and caregivers of patients/clients are implied each time a reference is made to patient/client.

4. What are the steps of the NCP?

The NCP consists of four distinct, interrelated steps. The process begins with **nutrition assessment**. Data collected during the nutrition assessment guides the RD in selection of the appropriate **nutrition diagnosis(es)** (i.e., naming the specific problem). The RD then selects the **nutrition intervention** that will be directed to the root cause (or etiology) of the nutrition problem and aimed at alleviating the signs and symptoms of the diagnosis. The final step of the process is **monitoring and evaluation**, which the RD uses to determine if the patient/client has achieved or is making progress toward the planned goals. These processes are described in a circle but might also appear to be linear. However, we acknowledge that during the course of an interaction/appointment with a patient/client, the RD will often complete the assessment and diagnosis steps, and may begin a Nutrition Intervention when a patient/client reveals another piece of new assessment data/information that will cause the RD to re-assess, and re-diagnose and perhaps modify the plan that he/she had started discussing with the client.

5. Is use of the NCP required by the Academy?

The Academy strongly recommends incorporation of the NCP by dietitians in all care settings and it is a required part of dietetic education and the RD and DTR exams; however RDs are not required to use the NCP. It is hoped that, once the value of the NCP is realized, RDs will choose to adopt it in their care setting. We are working with healthcare accrediting agencies, such as The Joint Commission so that when they evaluate nutrition services they will use the NCP and Model to guide evaluation of nutrition services. We are also working with the informatics community to incorporate terms used in the NCP in electronic health records.

6. What's in it for me?

It depends on where and how you practice.

While there may be a significant time commitment in the initial implementation stages, use of the NCP can eventually save time by serving as a framework for decision-making and documentation regardless of the setting. The NCP will also allow development of large databases of information needed to demonstrate the value of the RD, which may lead to improved reimbursement. Therefore, the payoff to the individual RD is a higher likelihood for reimbursement, ease of gathering data to document the value of the RD, and improved daily workflow.

If you are a clinical RD, the NCP will provide a framework for connecting data collected during nutrition assessment to each of the other steps. Decision-making will be facilitated by use of evidenced-based medicine (EBM), including the Academy's evidence-based nutrition practice guidelines. Use of the standardized language of dietetics will simplify documentation and provide a common understanding of the work that RDs do.

If you are an educator, the NCP will provide a framework for teaching dietetics students how to provide nutrition care. It will also serve as a way to structure student/intern evaluation forms to assure that each step is adequately addressed in the process.

If you are in public health/community nutrition, you can use the NCP as the way you structure your grant applications by discussing the assessment of the community/population data, the type of nutrition diagnosis(es) (problem(s)) that you need to address, what types of interventions will be employed, and how you will monitor and evaluate the outcomes. The rest of the model will be useful in explaining the contextual factors that impact the whole process (the social systems, healthcare system, practice settings and economics). The second ring can describe the capabilities that an RD can bring to the project if you are intending to justify RD involvement.

If you are a Food and Nutrition Service Department director or Clinical Nutrition Manager in healthcare (either acute care or long term care), you will find the NCP and Model useful in describing how the RD contributes to the overall healthcare provided in the institution. It is a pictorial model used to communicate among healthcare providers what the contributions of the RD are to the healthcare system when they provide nutrition care. It can be used to establish position description activities that are expected and serve as the framework for productivity measurement and performance evaluation of clinical dietetics and ambulatory staff.

If you are a research dietitian, you can use the framework to think about the types of data that you will need to collect from each step in the process as well as how you will want to structure your intervention. It will be useful in describing the implications of research to practice.

7. Does the NCP apply to dietitians who are not in clinical practice?

It depends. The NCP and Model is based on the scientific problem solving method. Many of the principles are transferable; however the application is to those who are involved in providing nutrition care. Because the NCP acts as a framework for critical thinking and decision making, it can be utilized by RDs working in all settings that require these skills, including clinical, management, food service, research, community, and education. Every member of the dietetics profession needs to be able to describe the NCP and Model whether they “USE” it themselves on a daily basis, interact with other members of the profession who do or supervise those dietitians who use it daily or not. It describes what over 50% of our members do every day.

8. Will I need to change the way I practice?

It depends. Advances in practice generally require new knowledge and adjusted behaviors. Adoption of the NCP is no different in that regard. Since the NCP has emerged from the process of nutrition care used by dietitians, it is an enhancement rather than a complete change. The biggest difference is naming a specific nutrition diagnosis/problem and writing it in a special “PES statement” format. If you haven’t been used to using a nutrition diagnosis and PES statement, then this will be a change for you. Documentation can also be streamlined by the NCP and the use of the standardized terms. You will likely find that you will need more time to work through the documentation when you start and therefore you may want to adjust your schedules and workload while you are learning the new terms.

9. What does it cost to implement?

The main cost is the time necessary to implement and adjust to a new way of approaching nutrition care. Resources are available on the Academy website to help with training and implementation. Many, including slides, sample case studies and audit forms, can be accessed at no cost to the Academy members. The manual, the *International Dietetics and Nutrition Terminology Reference Manual, Pocket Guide, Online IDNT and NCP Toolkits*, are available for purchase from the Evidence Analysis Library, [www.andevidencelibrary.com/store](http://www.andevidencelibrary.com/store).

10. Does the NCP affect charting?

The NCP can be worked into any charting or documentation system, however many dietitians are using the ADI or ADIME format which directly parallels the NCP (Assessment, Diagnosis, Intervention, Monitoring and Evaluation). It is recognized that in many settings the RD might not have the ability to change the format for documentation. In spite of this, use of the NCP will allow RDs to focus their chart notes and make documentation more concise. Examples of how the patient/client care would be documented using the ADI, SOAP, and Narrative format are available in the NCP section of the Academy’s website.

11. Will physicians understand the NCP and the way it is documented?

To date, feedback from physicians in various settings has been positive. More concise documentation with an explicitly stated nutrition diagnosis/problem and intervention plans to address the problem clarifies the RD’s unique role in the patient/client’s care. Use of the standardized terminology of dietetics has the potential to improve communication with physicians and other healthcare professionals through use of consistent definitions of terms used across settings. Many physicians are using electronic health record systems that incorporate standardized terminologies and thus may have increased appreciation for RDs’ need for standardized terminology.

12. Why is screening not included in the NCP?

Nutrition screening is a means by which patient/clients are identified for nutrition care. Screening can be done by many different personnel, it does not require a food and nutrition professional, and therefore it is not part of the NCP. Nutrition screening is considered an “entry” step to the NCP and is included in the overall “Model”, however it is not always completed by the RD or dietetic staff and therefore not part of the formal NCP.
13. What is the role of the DTR in the NCP?

The DTR works within his/her scope of practice and under the direction and supervision of the registered dietitian in accordance with both state and federal guidance. Refer to the Scope of Practice for additional information, [www.eatright.org/scope](http://www.eatright.org/scope).
14. Will using the NCP make my work more effective and efficient?

Some have noted a temporary decrease in productivity as staff learns the process. However, once the NCP is fully implemented, dietitians report improvements in organization and prioritization of daily tasks resulting in greater efficiency. Improved effectiveness comes when the more systematic approach to care produces better outcomes which are brought to light through the monitoring and evaluation step.
15. What is meant by standardized terminology? Do I have to learn a new language to describe the work I do?

With the advent of nutrition diagnosis, work began on the development of a standardized language for the NCP. Through a rigorous process over several years, terms for all four steps in the process (nutrition assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation) have been identified, organized and defined. These are available in the *International Dietetics and Nutrition Terminology Reference Manual*. Using standard terminology allows dietitians in all settings to use the same words to describe things resulting in more precise and effective documentation and communication. Standardized terminology is also essential for electronic health records and billing forms. Standardized language will also facilitate legislative efforts. Each term has a reference sheet that defines the term and important information regarding use of the term.
16. Where do the Academy’s Evidence Analysis Library and Guides for Practice fit in?

The Academy’s Evidence Analysis Library and Evidence-Based Nutrition Practice Guidelines are valuable resources that RDs can use throughout the NCP. They provide information that can guide selection of assessment methods and criteria and provide evidence for choosing the most effective intervention strategies and deciding what indicators to monitor. Toolkits are available for purchase to support these guidelines. Toolkits also contain sample forms that can be used for assessment, nutrition education and counseling, and documentation that follow the NCP and incorporate the standardized language.

17. How will the use of the NCP enhance reimbursement for nutrition care and/or RD compensation? Will this improve the chances that the hospital administration will recognize my value?

It is difficult, if not impossible to determine the impact of the NCP on RD salary levels. However, there is certainly the opportunity to use the NCP to demonstrate to administrators the positive outcomes associated with nutrition care by the RD. The hope is that someday we will have enough research/data to connect the various Nutrition Diagnoses and Interventions to outcomes and can begin to address the resources needed. Dietitians can then follow the model of the Medical Diagnostic codes which have been bundled and used to identify estimates of reasonable costs. We should be able to capture the complexity of the nutrition issues and corresponding resources needed to address them. When this occurs, then we will have sufficient data to address the reimbursement and payment systems.

18. How can I get more information?

The Academy's website front page has a link to many more documents and many resources for those interested in learning more about the Nutrition Care Process at [www.eatright.org/ncp](http://www.eatright.org/ncp). Also, contact [ncpslpermissions@eatright.org](mailto:ncpslpermissions@eatright.org) for more information or questions.

## **FAQs by NCP Step**

### *Nutrition Assessment and Nutrition Monitoring and Evaluation*

19. Do RDs need to document terms from all of the domains in Nutrition Assessment and/or Nutrition Monitoring and Evaluation? What if, for example, there is no Biochemical Data, Medical Tests or Procedures for a patient/client?

RDs use judgment to determine the relevant information to document include the patient population, setting, disease state and severity as well as policies that may indicate which documentation elements are required, recommended or consistent with the standard of care for a patient/client or population.

20. The IDNT Reference Manual uses different lab value ranges than those used for my practice setting and population.

Laboratory parameters within the IDNT reference sheets are provided only for guidance.

- Laboratory values may vary depending on the laboratory performing the test.
- Scientific consensus does not always exist concerning selection of biochemical tests, laboratory methods, reference standards, or interpretation of data.
- Laboratory findings (normal or abnormal) may be evaluated for their significance or lack of significance depending on the patient/client population, disease severity, and/or treatment goals.



- Current national, institutional, and regulatory guidelines that affect practice should be appropriately applied to individual patients/clients.
  - Arrows used with laboratory values: ↑ represents above a reference standard and ↓ represents below a reference standard.
21. The Client History domain is not included as a domain in Nutrition Assessment. Why? Can Client History indicators be reassessed in follow-up notes?
- It is not believed that a change in Client History indicators is due to nutrition intervention. One example of a Client History indicator used only for nutrition assessment is physical disability. Practitioners include physical disability in a nutrition assessment if it is relevant to the patient/client's nutrition diagnosis and/or nutrition intervention. However, the practitioner cannot change the physical disability through nutrition intervention; therefore, physical disability is not included in nutrition monitoring and evaluation as an indicator of the impact of nutrition care. Another example of an assessment indicator not used in monitoring and evaluation is medical history data, since nutrition intervention does not influence the presence or absence of a medical diagnosis (or diagnoses). Although Client History Domain indicators are not used for nutrition monitoring and evaluation, they may be reassessed for their presence and impact on nutrition care.
22. How do I document the monitoring and evaluation step?
- Dietitians should monitor outcome indicators that are relevant to the patient/client's nutrition diagnosis and intervention goals. The "as evidenced by" signs and symptoms in the PES statement are appropriate things to monitor.
23. How do I document progress in resolving a nutrition diagnosis?
- If you wish, you can determine the appropriate method for documenting progress in nutrition diagnoses based upon your patient/client population. One approach, developed by UPMC Presbyterian Shadyside:
- *"Resolved"*– nutrition diagnosis no longer exists because it has been addressed
  - *"Improvement shown/unresolved"*– nutrition diagnosis still exists but signs/symptoms showing improvement. Patient/client making progress.
  - *"No improvement/unresolved"* – nutrition diagnosis still exists, little to no improvement shown, still appropriate for patient/client's condition
  - *"No longer appropriate"* – nutrition diagnosis is no longer exists because patient/client's condition or situation has changed. The focus of nutrition interventions no longer supports the nutrition diagnosis.

The NCP/SL Committee is currently reviewing and considering recommendations for this concept.

## Nutrition Diagnosis

24. What is the nutrition diagnosis?

The nutrition diagnosis is the identification and labeling of a nutrition problem that the RD is responsible for treating independently. Standardized terminology for nutrition diagnosis has been developed to facilitate this step and is described in the International Dietetics and Nutrition Terminology Reference Manual. Examples of nutrition diagnoses are: “inadequate energy intake”, “overweight/obesity”, “food and nutrition related knowledge deficit” and “limited access to food or water”. It is suggested that the RD use a PES Statement to communicate the nutrition diagnosis (problem, etiology, and signs/symptoms).

25. What is a PES Statement?

The PES statement names the **nutrition problem (P)**, identifies its cause (or **etiology (E)**), and lists the assessment data (**signs and symptoms (S)**) that justify the problem. It is written as: nutrition diagnosis term “related to” etiology “as evidenced by” signs and symptoms of the nutrition diagnosis. This is a concise way of describing a nutrition problem that the RD is responsible for treating. The IDNT contains information that can assist the user in linking etiology and signs and symptoms with a specific nutrition diagnosis.

26. Must I write a PES statement every time I see a new patient/client?

If no nutrition problem is identified, then there is no need to write a PES statement. If you assess a patient/client that has been identified through a screening process and you determine that there is no immediate problem, then you would document “No nutrition diagnosis at this time (NO-1.1)” and would not initiate an intervention. (Writing Group of the Nutrition Care Process/Standardized Language Committee. Nutrition care process part II: Using the International Dietetics and Nutrition Terminology to document the nutrition care process. *J Am Diet Assoc.* 2008;108:1287-1293.)

27. Can I document more than one PES statement for a patient/client?

Yes. You can document more than one PES statement for a patient/client. Although, you can identify more than one nutrition diagnosis for a patient/client, it may be a good idea to limit them to PES statements that have been or are being addressed through nutrition interventions.

28. What is the difference between a nutrition diagnosis and a medical diagnosis?

In simple terms, a food and nutrition professional identifies and labels a specific nutrition diagnosis (problem) that, in general, he or she is responsible for treating independently (e.g., excessive carbohydrate intake). With nutrition intervention, the nutrition diagnosis ideally resolves. In contrast, a medical diagnosis describes a disease or pathology of organs or body systems (e.g., diabetes). In some instances, such as the nutrition diagnosis Swallowing Difficulty (NC-1.1), food and nutrition professionals label or diagnose the functional problem that has a

nutritional consequence. Food and nutrition professionals do not identify medical diagnoses; they diagnose phenomena in the nutrition domain.

29. What if there is still important nutrition assessment data pending that is needed to make a nutrition diagnosis?

Upon completion of an initial or reassessment, it is possible that a nutrition problem may not be identified; further information or testing may be necessary to make a determination; or the problem may not be modifiable by further nutrition care and discharge or discontinuation from this episode of nutrition care may be appropriate. If the assessment indicates that no nutrition problem currently exists that warrants a nutrition intervention, food and nutrition professionals may use the term “No nutrition diagnosis at this time (NO-1.1).”

(<http://www.eatright.org/ncp/>. Writing Group of the Nutrition Care Process/Standardized Language Committee. Nutrition Care Process part II: Using the International Dietetics and Nutrition Terminology to document the nutrition care process. *J Am Diet Assoc.* 2008;108:1287-1293.)

30. Can I document that a patient/client is “at risk of or has the potential for....” a particular nutrition diagnosis?

There are no data that show a cause-and-effect relationship between nutritional risk and nutrition diagnoses; therefore these modifiers are not recommended and should not be used.

Specific predicted problems can be identified based upon observation, experience or scientific reason. Future intake, that is predicted to be inconsistent with needs or problematic, may be documented. Study findings which demonstrate inadequate energy intake ~~low~~ in a specific subgroup (e.g., cancer chemotherapy patient/clients receiving a specific regimen) may lead the RD to infer that an individual or a group who is a member of the subgroup may also have low energy intake during future planned treatment or therapy.

The predicted diagnoses are not the same as labeling a patient/client “at risk.” Evidence to support a specific predicted problem is necessary to formulate the PES. There are five predicted nutrition diagnoses.

31. What nutrition diagnosis is appropriate for palliative or end-of-life care?

The term “No nutrition diagnosis at this time (NO-1.1)” may be documented in the medical record if the assessment indicates that no nutrition problem currently exists that warrants a nutrition intervention (<http://www.eatright.org/ncp/>. Writing Group of the Nutrition Care Process/Standardized Language Committee. Nutrition Care Process part II: Using the International Dietetics and Nutrition Terminology to document the nutrition care process. *J Am Diet Assoc.* 2008;108:1287-1293.). RDs can also use other nutrition diagnoses if desired.

32. What nutrition diagnosis is appropriate for a patient/client with a food allergy?  
Presence of a food allergy can be documented in the Client history (CH-2.1.8) and previous diets followed due to the food allergy are documented using the term Food allergies (FH-2.1.2.5). The next step is to determine if there is a nutrition problem associated with the allergy. Some individuals manage without any difficulties. These are some of the potential nutrition diagnoses if the patient/client has a nutrition problem.
- Food and nutrition-related knowledge deficit (NB-1.1). The patient/client is uncertain what foods to eat and those to avoid.
  - Limited adherence to food and nutrition-related recommendations (NB-1.6). The patient/client is reluctant to share food allergy information with servers at restaurants and risks exposure to allergens.
  - Inadequate intake of X nutrient. A specific nutrient (s) is missing from the patient/client's intake related to his/her modified intake. Refer to Nutrient class within the Intake nutrition diagnoses.
  - Excessive intake of proteins or amino acids (NI-5.7.2) or Less than optimal intake of types of proteins or amino acids (specify) (NI-5.7.3). The patient/client intentionally or unintentionally consumes an excess amount of a particular protein allergen.
33. Can nutrition diagnoses be combined if a patient/client has more than one?  
It is not recommended that RDs combine nutrition diagnoses into one PES statement since the etiologies (E) and signs/symptoms (S) are often different for each nutrition problem. If the etiologies and signs and symptoms are the same, select one problem as the primary problem to address. The other nutrition diagnosis can be listed as a secondary nutrition diagnosis if desired.
34. Should all of the nutrition diagnoses for which RDs plan to provide a nutrition intervention be listed in documentation/reports?  
RDs use judgment to determine whether it is appropriate to list all of the nutrition diagnoses identified. The RD may choose to note all of the nutrition diagnoses, and according to priority, develop nutrition interventions. For example, an RD may document physical inactivity and inadequate fiber intake of a population, but begin by addressing physical activity. In another situation, an RD may document the most relevant nutrition diagnoses for the situation. For example, in the ICU, an RD may document inadequate enteral nutrition infusion and not document that the patient/client is obese since no nutrition intervention will be developed to address this nutrition diagnosis at this time.
35. Isn't the etiology of the nutrition diagnosis supposed to be something the RD can change? In other words, a medical diagnosis should not be a cause or etiology of a nutrition problem, right?  
There are situations when a medical diagnosis is the etiology in a PES statement. For example, with the nutrition diagnosis Swallowing difficulty, the etiology may be related to a surgical procedure. Yet, whenever possible it is ideal to identify the

root cause (etiology) of the problem that the RD can address with a nutrition intervention. If the RD cannot resolve the problem by addressing the etiology, then the goal is to lessen the signs and symptoms of the problem.

36. My patient/client is dependent upon an adult for his/her care. Who has the nutrition problem?

The patient/client has the nutrition problem which includes the patient, client groups, populations, families, and caregivers of patients/clients. In some cases, the relationship between the patient/client and the caregiver is very closely linked. A breastfeeding mother's low milk production may be the cause of inadequate oral intake in an infant. In this situation, the nutrition diagnosis/es (Inadequate oral intake [NI-2.1] and/or Breastfeeding Difficulty [NC-1.3]) and nutrition interventions are developed for both the mother (more frequent offers to feed or increased pumping) and for the infant (more frequent offers for feeding).

37. How can different RDs arrive at different nutrition diagnoses for the same patient/client?

Based upon education, experience and training, different food and nutrition professionals may identify different nutrition diagnoses for a patient/client. As with any patient/client nutrition care scenario, discussion and review may lead to identification of a "better nutrition diagnosis" or professionals may differ in their opinion regarding the nutrition diagnosis. The Academy encourages research to validate the content of nutrition diagnoses as well.

38. What is the difference between the nutrition diagnoses Inadequate oral intake (NI-2.1) and Inadequate energy intake (NI-1.2)?

Inadequate oral intake (NI-2.1) is a nutrition diagnosis where the RD is able to document food intake (FH-1.2.2), using comparative standards such as a national food guidelines (e.g., U.S. Dietary Guidelines, MyPlate) or diet quality index standards (e.g., Healthy Eating Index) or another comparative standard.

Inadequate energy intake (NI-1.2) necessitates an estimation of energy intake compared to a standard of estimated energy needs for effective use this nutrition diagnosis. If it is not typical in a particular nutrition care setting to calculate the patient/client's estimated energy intake, then Inadequate oral intake (NI-2.1) may be the better nutrition diagnosis to use in this situation.

39. When completing a follow-up note, should the complete PES be re-documented or can just the problem be documented?

The determination for documentation in a follow-up note is the responsibility of food and nutrition professionals and/or their organizations. The NCP/SL Committee does not require that the entire PES statement be documented in a follow-up note. The Committee also supports documentation of progress, or lack thereof, in resolving the nutrition diagnosis.

40. In the PES statement, should the actual measures be included or can one indicate that a lab value is elevated? For example, for a sign and symptom related to glucose, must the value of 178 mg/dL (9.879 mmol/L) be documented or is documentation of an elevated glucose sufficient?

The determination for documentation of an actual value or the food and nutrition professional's interpretation of the value is the responsibility of food and nutrition professionals and/or their organizations with consideration of the patient population, setting, disease state and severity as well as policies that may be present indicating what documentation elements are required, recommended or consistent with the standard of care for a patient/client or population.

41. What if food and nutrition professionals determine that a nutrition diagnosis does not exist?

If upon the completion of an initial assessment or reassessment it is determined that a nutrition problem does not exist or cannot be modified by further nutrition care, discharge or discontinuation from the episode of nutrition care may be appropriate. It may be appropriate to recommend monitoring and follow-up in a specified timeframe to assure that positive nutrition status continues.

(<http://www.eatright.org/ncp/>. Writing Group of the Nutrition Care Process/Standardized Language Committee. Nutrition Care Process part II: Using the International Dietetics and Nutrition Terminology to document the nutrition care process. *J Am Diet Assoc.* 2008;108:1287-1293.)

### *Nutrition Intervention*

42. What is a nutrition intervention?

The intervention is the purposeful action of the RD aimed at ameliorating or lessening the nutrition diagnosis. Common nutrition interventions have been categorized and defined in the IDNT reference manual. They include interventions, such as, "supplements," "nutrition related medication management," "nutrition education," and "nutrition counseling."

43. What Nutrition Interventions are used for patients/clients with respect to physical activity?

The most common Nutrition Interventions for physical activity are Nutrition Education and Nutrition Counseling. The Nutrition Intervention definitions for Nutrition Education and Nutrition Counseling were revised to make it clear that they include food, nutrition and physical activity.

### *General IDNT Use*

44. Can the NCP and standardized language be applied in electronic health records?

There are resources to assist RDs who are working with information technology (IT) staff in their institution to assure that NCP model and the standardized language are included in electronic health records as they are developed and modified. Please see the Academy's E H R Toolkit at [www.eatright.org/shop](http://www.eatright.org/shop) and information on NCP Content Use on the NCP Main Page, [www.eatright.org/ncp](http://www.eatright.org/ncp).

45. Should all three terminologies—Nutrition Assessment/Nutrition Monitoring and Evaluation, Nutrition Diagnosis and Nutrition Intervention—in the IDNT be used?  
Yes. All three terminologies should be used so that RDs can document, for example, that a specific nutrition diagnosis was determined using specific assessment criteria and a particular nutrition intervention was used to eliminate the problem. If the terms are used in accordance with their unique definitions food and nutrition professionals can document and compare problems, their interventions and the outcomes of nutrition care. It is very difficult to clearly demonstrate that RDs make a difference unless this type of documentation is available.
46. Should food and nutrition professionals document the “codes” that are with the terminology, for example, Excessive energy intake (NI-1.5, 10637)?  
Neither the alpha-numeric term codes (NI-1.5) nor Academy Unique Identifiers (10637) are recommended in nutrition documentation. Food and nutrition professionals should document only the terms (e.g., Excessive energy intake). The Academy includes the alpha-numeric codes in cases studies, for example, to educate food and nutrition professionals about the appropriate use of terms. In these instances, a footnote explains that the alpha-numeric codes should not be included in documentation.
47. Is it necessary for documentation or reports that are provided other professionals, to be in the ADIME (i.e. Assessment, Diagnosis, Intervention, Monitoring and Evaluation) format? Can the patient/client intervention and goals, for example, be listed first?  
The NCP and Model is a scientific problem solving method. Food and nutrition professionals can organize documentation or reports that result from that problem solving method, how they feel best communicates the information.
48. What is the Academy Unique Identifier?  
The Academy Unique Identifier is an essential element used by information technology (IT) professionals for data monitoring and tracking in electronic health records (EHRs). Food and nutrition professionals use this number to request data needed for reports and quality improvement.
- The Academy Unique Identifier is associated with a term and never changes. If the term is modified, then the original term and unique identifier are retired. The new term is assigned a new unique identifier.
  - The unique identifiers do not have a structure. Although unique identifiers were initially assigned in sequential order, there is no order for the identifiers, and they do not have meaning or show relationships between terms. This is in contrast to the IDNT alpha-numeric term codes (e.g., ND-1.1), which change as the terminology changes and demonstrate relationships between terms and groups of terms.

- Neither the Academy Unique Identifiers nor the alpha-numeric term codes are recommended in nutrition documentation.
  - Food and nutrition professionals should document only the terms (e.g., General, healthful diet).
49. Does the Academy recommend how food and nutrition professionals should prioritize information obtained during the nutrition care process?  
Prioritization of the nutrition assessment information is based upon the patient/client population, practice setting, and disease state and severity. Given the diverse settings in which the NCP/IDNT could be used, only the food and nutrition professional knowledgeable with the details can determine the prioritization of the nutrition care.
50. Does the Academy require organizations to pay to use the IDNT and what is the process?  
Please refer to the FAQs on NCP Content Use available at <http://www.eatright.org/HealthProfessionals/content.aspx?id=7077>.

Do you have additional NCP or IDNT questions? Please contact Donna Pertel at [ncpslpermissions@eatright.org](mailto:ncpslpermissions@eatright.org).