AMERICAN DATA

Dietary Notes

Document Dietary Assessment

1. From the Dietary Access menu, click **Dietary Assessment**, select name(s) (hold down the **CTRL** key on the computer keyboard if needing to select more than one name).
2. A two-way split screen will appear. The top half of the screen is a Write screen, and the bottom half is a View screen. The view screen will display previous notes and other pertinent information.
3. Document the assessment by working from left to right.
4. When finished documenting on this screen, click the **Sign** button.
5. The next topic will load. Once completed with the assessment, the user will be brought back to the Dietary Access menu.

Dietary Access	Charting	Chart Review	Reports		MDS/CAAs/ Care Plans	Schedule	Internal Memo
Main Menu	Progress Notes	Dietary Notes	Dietary Notes	Intake Averages	Continue Assessment	Resident	Write Internal Memo
	Dietary Assessment	Meal Intake	Weekly Weights	Diet List	View/Print Assessment	MDS	
	Tray Card	Risk Review	Weekly Weight Graph	Tray Cards	Work CAAs	Care Conference	
	Dining Services	Food Intake <75%	Monthly Weights	More Reports	Print CAAs		
	Record Meal Intake	View Chart	Monthly Weight Graph		Care Plans		
	DC Arrangements / Summary						

Dietary Assessment includes: Dietary Notes (progress notes), Nutrition Risk Assessment, Nestle MNA, Dietary Assessment (Section K items of the MDS), Tray Cards, and Dietary/Nutritional Care Plans.

Using the Clinical Calculator

This can be used to calculate the following items: BMI, BEE, IBW, Calorie Needs, Minimum Protein, Maximum Protein, and Total Fluid Needs. This will only calculate *accurately* if the resident's age, sex, height, weight, activity factor, injury factor, protein factor, and fluid factor *all* are documented.

1. From within the Dietary Notes portion of the Dietary Assessment, click **^Go To Dietary Calculations.**

2. Select **Tasks**.
3. Select **Dietary Calculations** and click **Load**.
4. Click **Name(s)** and select the desired resident.
5. Click **OK**.
6. Select **Calculate** in the top left portion of the screen.
7. Calculation results will be displayed. Review the results and select **Write All** at the top of the screen if you wish to save the calculations to the chart.
8. If "Write" was selected, calculations can be viewed following the instructions below for **Viewing Dietary Documentation**.
9. Click **Exit** to return to the Dietary Assessment.

Document Other Charting

1. From the Dietary Access menu, click onto the button to chart into, select name(s) (hold down the **CTRL** key on the computer keyboard if needing to select more than one name).
2. A two-way split screen will appear. The top half of the screen is a Write screen, and the bottom half is a View screen. The view screen will display previous notes and other pertinent information.
3. Document by working from left to right.
4. When finished documenting on this screen, click the **Sign** button.

Tray Cards: Can be used to indicate resident's dislikes, food sensitivities, meal preferences, and location of meals. This generates tray card reports which can be used to help staff during mealtimes.

Dining Services: Can be used to charge a resident for a guest meal. This can be used simply as a tracking tool if your facility does not use our Financial module in ECS.

Meal Intake: Can be used to chart a resident's meal intake. There are options for Breakfast, Lunch, and Dinner; as well as the capability to review meal intake charting completed by Dietary Aides or CNAs.

DC Arrangements/Summary: Can be used to document a resident's discharge summary and/or any of their discharge arrangements to be aware of. There are a couple reports including: Discharge – Plan of Care and Discharge Summary, which can be viewed from this screen as well.

View Charting Documentation

1. From the Dietary Access menu, click onto a button underneath the Chart Review column.
2. Select name(s) and click **OK**.
3. Select more than one resident by holding the **CTRL** key on the computer keyboard.
    a. If a Control screen appears, put in a start, and end date and click **OK**.

   i. Click Go at the top of the view screen to retrieve the notes in the specified date range.

4. When finished viewing, click Exit, which will take the user back to the Dietary Access menu.

Dietary Notes: Allows the user to select a date range and view all dietary notes completed within the specified date range. The date/time/initials of who completed the entry will display to the left of each entry. To view discontinued entries, click Control and place a check mark in D/C'd Entries. Next, click OK and then Go.

Meal Intake: Allows the user to select a date range and view all meal intake charting completed within the specified date range. This charting is typically completed by a Dietary Aide or CNA. The date/time/initials of who completed the entry will display to the left of each entry. To view discontinued entries, click Control and place a check mark in D/C'd Entries. Next, click OK and then Go.

Risk Review: Allows the user to select a date range and view all dietary "risk" notes completed within the specified date range.

This task will include residents with the following:

- A significant change in weight/vitals
- Orders for diet/supplements
- Orders for any of the following types of medications: antidiabetics, antacids, antiemetics, antihyperlipidemics, digestive aids, dietary products, diuretics, endocrine and metabolic agents, gastrointestinal agents, laxatives, multivitamins, minerals and electrolytes, nutrients, and ulcer drugs
- Meal intake of less than 50%

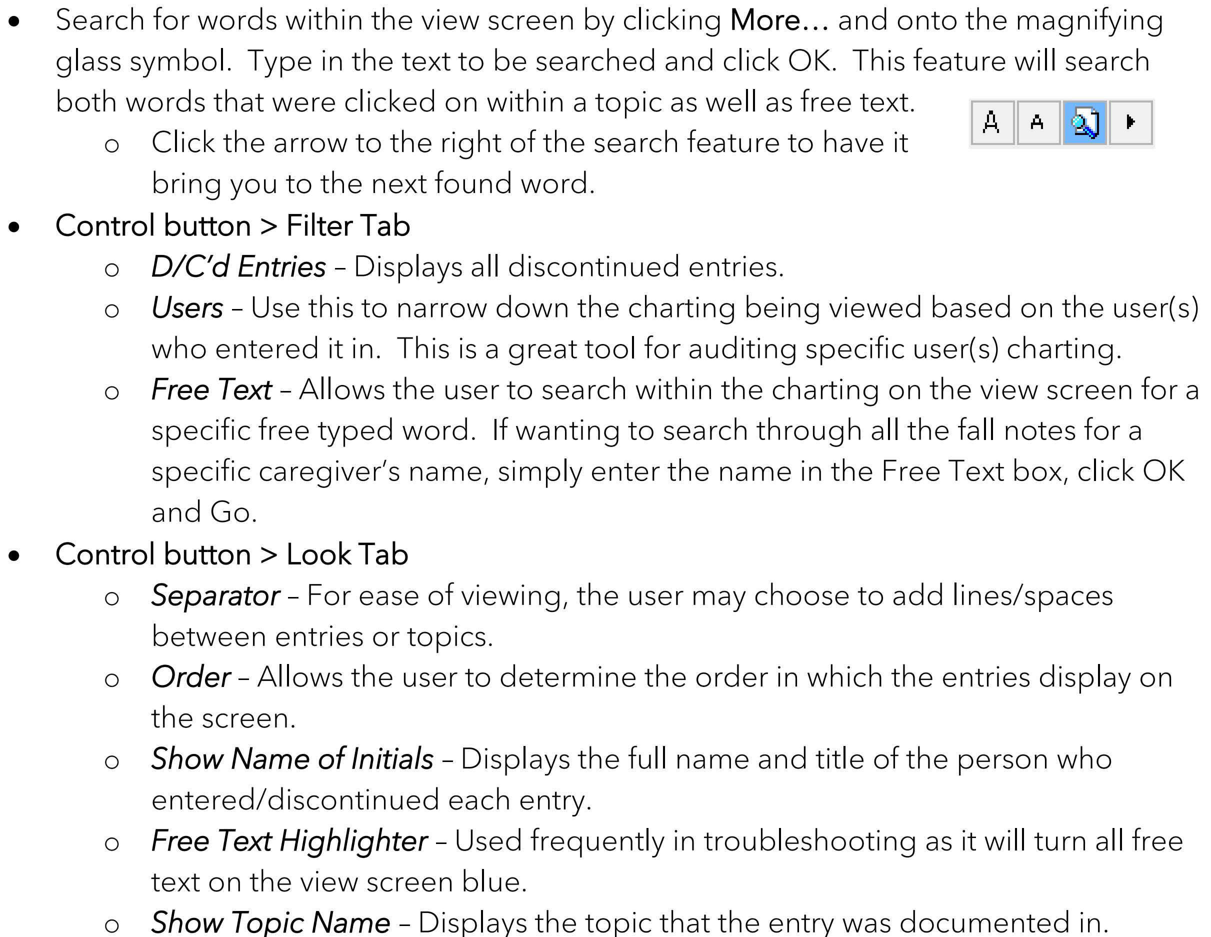
The date/time/initials of who completed the entry will display to the left of each entry. To view discontinued entries, click Control and place a check mark in D/C'd Entries. Next, click OK and then Go.

Food Intake: Provides a calendar report for the current month which displays any day(s) residents had an intake of 75% or less of their meal. This allows the user to focus on specific groupings to determine if the meal on that specific date was potentially not as popular as meals on other dates. Click Control to adjust the date ranges and then OK once new dates are selected.

View Chart: Allows a user to select any documentation within the records granted rights to view. Click Topic or Task to choose the area of the chart to be viewed. Click Control to select a start and end date. Click the Look tab to select other options to view (*i.e.,* show names of initials, topic name, cosign, or free text highlighter). Once all options have been selected, click OK and then Go to retrieve the requested information.

- Adjust the font size by clicking More… and clicking on the big or little "A."

- Search for words within the view screen by clicking **More…** and onto the magnifying glass symbol. Type in the text to be searched and click OK. This feature will search both words that were clicked on within a topic as well as free text.



  - Click the arrow to the right of the search feature to have it bring you to the next found word.
- Control button > Filter Tab
  - *D/C'd Entries* – Displays all discontinued entries.
  - *Users* – Use this to narrow down the charting being viewed based on the user(s) who entered it in. This is a great tool for auditing specific user(s) charting.
  - *Free Text* – Allows the user to search within the charting on the view screen for a specific free typed word. If wanting to search through all the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.
- Control button > Look Tab
  - *Separator* – For ease of viewing, the user may choose to add lines/spaces between entries or topics.
  - *Order* – Allows the user to determine the order in which the entries display on the screen.
  - *Show Name of Initials* – Displays the full name and title of the person who entered/discontinued each entry.
  - *Free Text Highlighter* – Used frequently in troubleshooting as it will turn all free text on the view screen blue.
  - *Show Topic Name* – Displays the topic that the entry was documented in.

Edit Assessments/Notes

1. Click the **Dietary Notes** button under the Chart Review column.
2. Select name(s) and click **OK**.
3. Select a date range and click **OK**.
4. Click **Go**.
5. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
6. Click **Edit**.
7. Click the desired editing feature.
8. When using Append, DC and Explain, or DC and Copy, make the desired change and then click **Next**.
9. Click **Go** to see your changes.

Editing features which are bolded are utilized most often in Dietary Documentation.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further	Cosigning a student's documentation

	editing will not be able to be done to the entry except to discontinue	
New	A new, separate entry made in the same topic area	Not typically used when editing department notes. Can be used to see where an entry was charted
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Client[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	Entry is discontinued and user is taken to a Write screen to document additional notes	An error was made in documenting the entry and the user would like to explain why the entry is being discontinued
Discontinue and New	Entry is discontinued and a new entry is made in its place	Not typically used when editing department notes
Discontinue and Copy	Entry is discontinued and a copy of the entry is displayed, allowing user to make changes to the original entry	User forgot to use a button word when documenting and would like to "insert" the word into the entry
Discontinue	Entry is discontinued	Not typically used when editing department notes
Discontinue All	All highlighted entries are discontinued for one client	Not typically used when editing department notes
Discontinue Multiple Client Entries	All highlighted entries are discontinued for multiple clients	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Accidentally highlighted an entry that does not need editing

View/Print Reports

1. From the Dietary Access menu, click the desired report button under the **Reports** column.
2. From the Name Selection screen, select the desired name(s) and click **OK**. Select more than one resident by holding the **CTRL** key on the computer keyboard.
3. Choose the appropriate date range if prompted to do so.
4. The report preview appears.
5. Click the printer icon in the upper left corner to print.
6. Click **Close** to return to the Dietary Access menu.

Dietary Notes: Prompts the user to select a date range. It then displays all dietary notes documented within that specific date range.

Weekly/Monthly Weights: Displays the last 12 weeks/12 months of weights, as well as any significant weight changes that may have occurred.

Weekly/Monthly Weight Graph: Displays the last 12 weeks/12 months of weights on a graph. This also pulls the resident's IBW, diet ordered, and any corresponding care plans. The graphs are interactive; thus, if you click a data point, it will take you directly to the corresponding entry.

Intake Averages: Displays a statistical report showing all the meal and snack intakes for the past week, as well as weekly averages.

Diet List: Displays all residents and their diet/supplement orders entered in the Physician Orders tab.

Tray Cards: Displays the 3-in-1 tray card option which includes all three meals listed on one tray card per resident. This can only be used if the facility is also documenting on the Tray Card screen.

More Reports: Displays all reports available within the system that the user has rights to. The user may select any report to view and click **OK.**

Write an Internal Memo

1. From the Dietary Access menu, click the **Write Internal Memo** button.
2. Once in the Internal Memo topic, the user will be presented with a pop-up that states, "This task has clients associated with it. Do you want to override your currently selected clients?" Always click **Yes**. (Messages written in this topic most likely will *not* have anything that belongs in their medical record, which is why a fake client is created to attach to this Internal Memo task so that all the messages written are on the fake client's record.)
3. Document the message to be sent.
4. Select a user group(s) to send the message to or click **pick user on Save** to select the person(s) from a user list once the entry is saved.