Optimizing Care Through RD Checks

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BACKGROUND:

Within our facility an intervention called RD check is utilized. RD checks are completed based on the dietitian's discretion with a brief note in the hospital computer system. This allows for more frequent monitoring and adjustment to the patient's plan of care to achieve nutritional goals. Required documentation occurs in the medical record at established timeframes per policy. Due to staffing constraints, required documentation is prioritized over RD checks which led to decreased monitoring of the plan of care. This delay in the monitoring and evaluation of nutritional interventions can negatively affect the timeframe patient's achieve their individualized nutrition goals.

OBJECTIVE:

Streamline documentation to reduce charting in multiple areas to ensure all required patient encounters are completed.

METHOD:

A Kaizen (root cause analysis) was completed. It was identified that duplicate documentation of information occurred in the plan of care and on the RD work list. Additionally there was no established way to identify highest priority RD checks. The team collaborated on developing a Standard Operating Procedure (SOP) to assist clinicians to streamline documentation of RD checks utilizing the nutrition flow sheet and the nursing care plan. The SOP included a method to identify high priority checks.

RESULTS:

Results of countermeasures implemented revealed a 35% improvement for a typical RD check average time and a 28% improvement in complex RD checks.

CONCLUSION:

A Standard Operating Procedure and streamlined documentation promotes an efficient process for RD checks.