



NOVA SCOTIA COLLEGE OF
Dietitians AND
Nutritionists

Documentation Guidelines for Dietetic Practice

Nova Scotia College of Dietitians and Nutritionists

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The Nova Scotia College of Dietitians and Nutritionists (NSCDN) is the regulatory body for the profession of dietetics in Nova Scotia. In the public interest, the NSCDN regulates dietitians and nutritionists to practice in a safe, ethical and competent manner.

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Introduction

Appropriate documentation is an entry-level standard of practice for dietitians¹, therefore these guidelines are intended to outline a dietitian's accountability for documentation and guide documentation practices.

Clear, comprehensive and accurate documentation provides a record of how a dietitian applies their knowledge, professional judgment and critical thinking skills. Documentation in a client's health care record also serves as a way to communicate with the interprofessional team to help ensure all of those involved in a client's care have access to information on which to plan and assess their interventions. The NSCDN will rely on a dietitian's documentation when complaints are made about their practice. Documentation must comply with applicable legislation, regulations, standards of practice, and policy directives relevant to the practice of dietetics in Nova Scotia, as well as applicable workplace policies. The following guidelines are applicable to dietitians that provide service to individual clients or groups in both clinical and non-clinical settings. Dietitians have a professional and legal obligation to keep their clients' personal health information confidential and private as outlined in NSCDNs [Standards of Practice](#). The collection, use, disclosure, retention, disposal and destruction of personal health information shall comply with the Personal Health Information Act (PHIA) and workplace policies. Where informed and voluntary consent is required for the collection, use, or disclosure of personal health information, dietitians must comply with applicable legislation, standards of practice, the code of ethics, and workplace policies. Disclosure of information without consent (where required) must be documented. For more information on consent, refer to NSCDNs Standards of Practice.

¹ The title of dietitian is used throughout the document, and means any NSCDN member who refers to them self with any of the profession's protect dietitian, registered dietitian, nutritionist, professional nutritionist, professional dietitian, R.D., R.D.N., P.Dt ed titles, or any derivation, translation or abbreviation of those designations.

Characteristics of Acceptable Documentation

Clear – Uses appropriate language, including acronyms and abbreviations that are defined and accepted within a particular work setting.

Concise and complete - Includes the essential information to fulfill the purpose.

Accurate – Free of error (to the best of the dietitian’s ability).

Relevant - Reflects important issues regarding service(s).

Objective - Based on observations and supported by facts; may also include relevant subjective assessment data based on professional judgment.

Retrievable – Information is easy to locate within the client health record.

Confidential - Respects the confidentiality and privacy of the client and others.

Client-centered - Incorporates client and/or family goals and perspectives.

Setting-specific - Uses applicable workplace forms, methods or systems for documentation/reports.

Timely - Information is recorded in charts and/or consult reports are completed and sent to referral source as per organizational requirements or within 24 hours.

Chronological – Events are recorded in the order that they occurred.

Professional – Respects others and their entries by sharing and seeking accurate information and in particular referencing sources of the information.

Non-judgmental and respectful - Avoids derogatory remarks.

Documentation for Practice in Direct Client Care

The NSCDN supports the adoption of the Nutrition Care Process Terminology (NCPT), as it has the potential to facilitate consistent, safe and quality dietetic documentation across a variety of dietetic practice environments. Dietitians are accountable to practice and document according to the nutrition care process in the health record for each client they have consulted. Nutrition care documentation for individual client interactions should provide a clear picture of the nutrition assessment and findings, recommendations, and interventions (including advocacy, counseling, consultation and teaching). Documentation should be according to identified monitoring parameters. Transfer of care and discharge summaries may often contain the same information as consult reports, in addition to why the treatment is ending, recommendations for on-going self-management and follow-up by another dietitian or health professional.

The guidelines in this document apply to both paper-based and electronic records. If both paper and electronic records are used, it should be noted within both formats that the record is made up of both systems and that together these two systems make up the entire record. Dietitians maintaining shadow charts² should follow applicable organizational policies related to shadow charts. All original documentation is maintained on the client's health record, however shadow charts may include copies of nutrition care notes, consult reports or other applicable information to the nutrition care process (e.g. calculations). Dietitians need to ensure shadow charts are kept secure in order to protect client confidentiality and privacy.

Dietitians should also consider documenting

- in a manner consistent with the overall goals of care;
- the inability to provide or complete nutrition consult and reasons (e.g. inability to contact client, client refusal of nutrition service, cancelled/missed appointments, referral to another dietitian or health care provider);
- the client's understanding, agreement/disagreement with nutrition care plan, and/or client action/inaction that may be considered at odds with achieving nutrition-related goals;
- when express consent is attained or refused/withdrawn for nutrition prescription;
- when express consent is attained or refused/withdrawn for or collection/use/disclosure of personal health information, as applicable; and
- consent to communicate with a client via electronic means (e.g. email).

How to document

Documentation not only serves to communicate with the health care team but serves in a legal proceeding. Nutrition care should be documented using a format and manner that complies with applicable workplace policies and facilitates the use, sharing, and ready retrieval by authorized individuals. Documentation may follow a specific format such as SOAPE (subjective, objective, assessment, plan, evaluation), DARP (data, action, response, plan), Nutrition Care Process (assessment, diagnosis, intervention, and monitoring and evaluation), or a similar approach. Documentation may also be narrative and/or workplace approved pre-printed forms may be utilized. Every entry must be dated and dietitians must clearly identify themselves when documenting their dietetic services, including their name (signature and printed) and professional designation to demonstrate accountability.

If a correction is required, make a single line through the error ensuring that the correction and the original note are both legible. Correction tapes and fluids are not appropriate as they obscure the original documentation. Sign and date (and time if necessary) when a correction is made, and depending on the urgency of the correction, communicate the correction to other health care providers by additional means. An appropriate correction process should be established within any electronic documentation system. Records should have a way to indicate when corrections are made and ensure that viewing of the original documentation is easily available in case anyone should need to access it.

² personal notes are separate from the health record.

Documentation of a nutrition intervention should occur within 24 hours of the intervention, however if this is not possible, the dietitian may document the entry as late, by documenting when the intervention occurred, and sign the entry with the current date.

Documentation with pencil, gel pens, or color highlighters is not recommended as they are not permanent, can be erased or changed, and do not photocopy/scan/fax well. Documentation on color paper is also not recommended as documentation may not be legible when scanned/photocopied/faxed. There should be no blank or white space in paper-based documents as this presents an opportunity for others to add information. An accepted practice is to draw a single line completely through the white space, including before and after your signature. Use of abbreviations and symbols that are obscure, obsolete, poorly defined or have multiple meanings can lead to errors, cause confusion and waste time. Use only those abbreviations, symbols and acronyms that are widely understood by health care providers (HCP) and/or approved within applicable workplace.

Dietitians engaging in prescribing shall have clear and concise documentation that follows workplace policies and procedures. Documentation must represent the prescribing decisions and nutrition care that is provided to the client. For more information related to nutrition prescription, refer to NSCDNs [Nutrition Prescription Standards](#).

Documentation in a collaborative health care setting

Not all information in the client health care record needs to be included in the nutrition care notes. In practice settings where dietitians are working with other HCPs, the full health record in its entirety makes up the complete client health record. When background health information is provided by another practitioner, it need not be duplicated; however, a reference to the appropriate section should be included in the nutrition note.

Dietitians engaging in combined counseling and/or documentation with other HCPs should ensure they meet their requirements for documentation, clearly identify themselves, and document services provided. If another HCP documents the combined counseling session, including the nutrition intervention, dietitians should review and sign to indicate agreement with the content.

Documentation in a private practice setting

A dietitian who consults with individual clients in their own private practice has custody or control over their client's personal health information. Private practice dietitians must understand and comply with their custodian duties as legislated under PHIA. For more information on PHIA, refer to [Toolkit for Custodians: A Guide to the Personal Health Act Information](#). PHIA does not specify how long client health records should be retained. Consider retaining records for ten years, and ten years after the age of majority (e.g. 19 years old) for minors.

In addition to nutrition care notes, dietitians in private practice should ensure that a client's health record contains:

- the client's full name and address;

- the date of each client visit;
- the name and address of the primary service provider and any other referring health professional, if applicable;
- the reason for referral, if applicable;
- the client's relevant health history including medical, social, familial, and economic data related to the nutrition assessment;
- copies of any reports received from other health care providers/organizations (with appropriate consent); and
- copies of invoices and receipts issued to clients.

Where equipment is required to conduct a patient assessment, a dietitian should keep maintenance/service records (e.g., calibration of weight scales), certificates or other records as applicable to indicate they are trained and competent to use the equipment.

Fees and Billing

Financial records must be maintained whenever billing occurs, including receipts issued and payments received. Dietitians shall ensure that financial information is documented in the client health record, RD financial record, or both, and stored securely. For more information related to fees and billing, refer to NSCDNs Standards of Practice.

Documentation for services delivered via technology and/or telepractice

Accountability for documentation is the same for services delivered in-person, via technology (e.g., email, telephone), or via telepractice (electronic dietetic practice outside of where the dietitian is registered via internet, email, telephone, videoconference or other electronic means). For more information related to telepractice, refer to NSCDNs [Virtual Practice Policy](#).

All communication with clients via email, telephone or telepractice shall be documented and placed on the client's health record. Email correspondence may be printed and filed on the client health record or cut and pasted to the client's electronic health record unless other workplace policies exist. Client consent for communication via email should be obtained and documented due to increased risk of a confidentiality and/or privacy breach with this mode of communication.

Signing dietetic interns' chart notes

Dietitians have a professional responsibility to understand and uphold their ethical duties as preceptors as per the Code of Ethics. It is reasonable to expect that dietetic interns sign their own documentation in the clients' health records. If dietitians co-sign dietetic intern documentation, they should indicate the reason for the co-signature (e.g., information in the documentation is correct, agree with the content).

Non-Clinical Documentation

Documenting in an institution-based food service setting

Documentation should align with organizational policies, health and safety requirements, relevant legislation, and other factors impacting food services. Document information and implement policies that demonstrate the delivery of safe food services where there is a potential for error and risk to clients.

Documentation and or record keeping may include:

- nutritional content of menu items and/or ingredient lists and compliance with applicable standards, therapeutic diets and nutrition policies;
- menu development and modification principles;
- food production and distribution procedures/policies and compliance with health, food safety, sanitation and infection control protocols/standards;
- technical requirements and equipment service records (e.g., calibration of temperatures in refrigerators, ovens);
- contracts with foodservice suppliers, including compliance with safety standards;
- purchasing, receiving, storage, inventory control and disposal activities;
- costing/financial reports;
- staffing needs/scheduling;
- complaints received regarding food services and any remedial action taken;
- quality assurance and quality improvement mechanisms;
- staff meeting minutes;
- individual staff files to record absenteeism, inappropriate conduct/performance reviews and document of conversations and/or actions put into place to address performance; and
- records of feedback, surveys, sensory evaluations, or audits conducted.

Documentation for presentations and workshops

Dietitians who provide services to groups (e.g. public speaking events, supermarket tours) should consider documenting the following:

- An assessment of the group/community needs;
- The purpose, objectives or expected outcomes of any meeting/presentation;
- The plan for meeting the objectives;
- The interventions/education (e.g., class content, location) to execute the plan;
- Materials and handouts used in the presentation;
- Frequently asked questions to guide content and highlight topics that require further resource development;
- An evaluation of the interventions, outcomes and future plans; and
- Program attendance.

Unless required by employer, dietitians may not need to keep individual client records.

However, if an individual conversation occurs with a group member where individualized advice is being requested and been provided after a nutrition screening or assessment has taken place (e.g. you have asked a nutrition history or medical information of an individual group member), then you are conducting an assessment and need to create an individual health record.

Documentation in other non-clinical settings

Dietitians work in a variety of non-clinical settings, such as public health, universities, community, research, industry, marketing, media and sales. Principles and guidelines outlined in this document are also applicable in these settings. Specific documentation requirements as well as documentation retention schedules in these settings are best determined by dietitians and their employers in order to best suit their purposes and ensure compliance with applicable legislative requirements and/or workplace policies.

Documentation for dietitians working in these settings may include:

- appropriate evidence-based documentation to support any verbal or written communication/resources, promotion or expert opinion of nutrition related products/services in any media;
- contracts or written agreements pertaining to provision of a service and/or completion of a project that clearly outlines the obligations of all parties involved, goals, deliverables, timelines and remuneration which should be dated and signed by all parties;
- documentation of conversations where specific advice/recommendations are provided regarding nutrition or professional practice related issues and/or referral to another professional or service if more appropriate;
- meeting minutes or summaries and any agreed upon action items;
- documentation of any complaints/disputes and action(s) taken to resolve the same;
- documentation of incidents or conversations related to misconduct or staff performance issues and appropriate reporting of same;
- equipment service/maintenance records as applicable; and
- proof of additional certification/training.

Consider keeping records and/or files of phone calls/emails/faxes pertaining to any of the above scenarios as well as contracts, invoices/receipts for services rendered.

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