The Association of UK Dietitians

Model and Process for Nutrition and Dietetic Practice

Summary

This guideline introduces the revised British Dietetic Association Model and Process for Nutrition and Dietetic Practice, abbreviated to 'Model and Process'. The purpose of the Model and Process is to describe, through the six steps, the consistent process dietitians follow in any intervention; with individuals, groups or populations, in clinical settings, public health or health promotion. The Model and Process also articulates the specific skills, knowledge and critical reasoning that dietitians deploy, and the environmental factors that influence the practice of dietetics. The Model and Process does not take away dietitians' autonomy. Instead, it enables a consistent approach to dietetic care, with the service user at the centre.

Background

In the UK, the Nutrition and Dietetic Care Process was first described in the curriculum learning outcomes published by the Dietitians Board in 2000 and the Standards of Proficiency set by the Health and Care Professions Council (HCPC) since 2007. Since this time, it has been included in updated versions of the BDA curriculum (1) and HCPC Standards (2) to make explicit the components of a dietetic intervention in order to facilitate professional practice.

In 2006, the BDA published the Nutrition and Dietetic Care Process (3) to describe the knowledge, skills and the critical thinking employed by dietitians. The Nutrition and Dietetic Care Process was influenced by the Academy of Nutrition and Dietetics' (formerly the American Dietetic Association) Nutrition Care Process and Model (4). The Nutrition and Dietetic Care Process was reviewed in 2012 and renamed Model and Process for Nutrition and Dietetic Practice. This was updated in 2016 by a working group of the BDA Professional Practice Board (4). This current document was updated in 2020 by the BDA Outcomes Working Group.

Introduction

The Model and Process demonstrates how dietitians integrate professional knowledge and skills into evidence-based, clinical reasoned decision making using the six steps highlighted below. Therefore, it differentiates between dietitians and other professionals who provide some nutrition services. It describes the contribution of dietitians in different practice areas including clinical, public health, and health promotion, whether working with individuals, groups or communities.

Health professionals may feel concerned that following and systematically recording a set process may undermine their professional autonomy (5). This is not the intention of the Model and Process. The Model and Process identifies the steps, skills, resources and knowledge used by the dietitian within an intervention but does not replace the dietitian's decision making on their practice or record keeping. At each step, the dietitian makes choices between assessment tools, considers the evidence-base, identifies and prioritises the most important aspects for action, and decides on the most appropriate interventions needed. In this way, the Model and Process facilitates autonomy of practice, and does not replace it.

Application

The systematic application of the Model and Process in education settings, clinical and public health practice will demonstrate the unique skills of the dietitian and provide consistently high standards of dietetic practice. When describing and recording the steps of the Model and Process, standardised language should be used across the profession to ensure terminology is consistent. This will enable us to better collate and compare outcome data (6). In order to facilitate this, the BDA has worked to translate electronic Nutrition Care Process Terminology (an international dietetic specific terminology), into SNOWMED Clinical Terms (SNOMED CT) and has published recommended terms for use in electronic records. These terms of use are embedded within the BDA Outcomes Framework which can be downloaded and used by departments to record and monitor outcome data. Outcome data must be collected and stored in line with General Data Protection Regulation as well as any relevant local/national policies.

Benefits to using the Model and Process

The Model and Process supports the development of consultation skills, clinical reasoning and a consistent standard of practice.

Structure

The Model and Process, when integrated into accepted documentation standards, supports an agreed structure for paper and/or electronic dietetic records. Anecdotally, some dietitians report that using the Model and Process leads them to record in a more structured and succinct format; including structured reporting to other professions which is valued by both parties.

The action focussed approach to recording of the diagnosis, strategy and implementation, enhances communication between service user, dietitian and other professionals and clearly directs the intervention. The service user's ideas, priorities, concerns and expectations should be integral to this approach.

The Model and Process also requires that the critical reasoning employed throughout the intervention is clearly communicated. This structure should ensure a consistent quality of dietetic care for service users.

The Model and Process does not replace locally or nationally agreed record keeping standards and requirements and should be integrated into locally agreed structures for documenting dietetic interventions.

Outcomes

Monitoring and measuring service demand, service developments and improvements, as well as evidencing the effectiveness of dietetic services, can be done by collecting and evaluating data through the Model and Process steps.

One recommendation from the NHS five year forward view (7) was that programmes must be designed to narrow variation in outcomes and thus reduce health inequalities. Measuring outcomes enables us to identify processes that are effective as well as those that may need adapting; to improve service user care and ensure a cost-effective service is provided with resources allocated accordingly (8,9).

Measuring national-level outcomes has improved the quality of care in the NHS; evidenced by improving cancer survival rates and declining heart attack and stroke death rates (10). Measuring outcomes enables us to measure our effectiveness as a profession.

The European Federation of the Associations of Dietitians recommend that all dietitians should document outcome data from dietetic interventions and that standardised language should be used to ensure this data can be aggregated, pooled and compared locally, nationally and internationally (6)

Whether you are working in healthcare or another area of practice, there are multiple benefits to collating and evaluating outcome data:

- For professionals – it supports decision making around the delivery of effective interventions, education, training and messaging, supports service planning and product design, and helps to promote productivity and job satisfaction.
- For service users – it demonstrates they are receiving an effective service that makes a difference to their health and quality of life, values their experience in the future services and products that affect them.
- For commissioners, boards and businesses – it demonstrates they are commissioning or buying the most efficient and effective service

The Model and Process is designed to both move the profession towards evidence-based practice and, with consistent application, to demonstrate to others that dietitians are evidence-based practitioners and diagnosticians (11).

Layers of influence

No dietitian practices in isolation. The image below illustrates the levels of influence on the practice of a dietitian.

The immediate and most powerful influence is the relationship between the service user(s) and the professional. The image below, along with the Model and Process both clearly illustrate that the service user is at the centre of all dietetic practice. This ensures the service user and their experience is at the heart of quality improvement (16). The service user brings their culture, beliefs and attitudes to the intervention, and these values guide shared decision making. Patient centred care is integral within statutory health services. The definition of patient centred from the Institute of Medicine is

'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions' (17)

The other layers of influence on practice are professional and individual, such as the evidence base for professional practice, professional ethical codes and the individual's capabilities and scope of practice.

Further influences are those relating to the organisation in which the services are delivered such as the structures and pathways in place along with the resources available; human, financial and physical. All of these are tempered by the national and strategic environment which governs the health, economic and legal systems which facilitate or constrain practice and which shape, and are shaped by, the social systems.

Figure 1: Layers of influence

The Model and Process

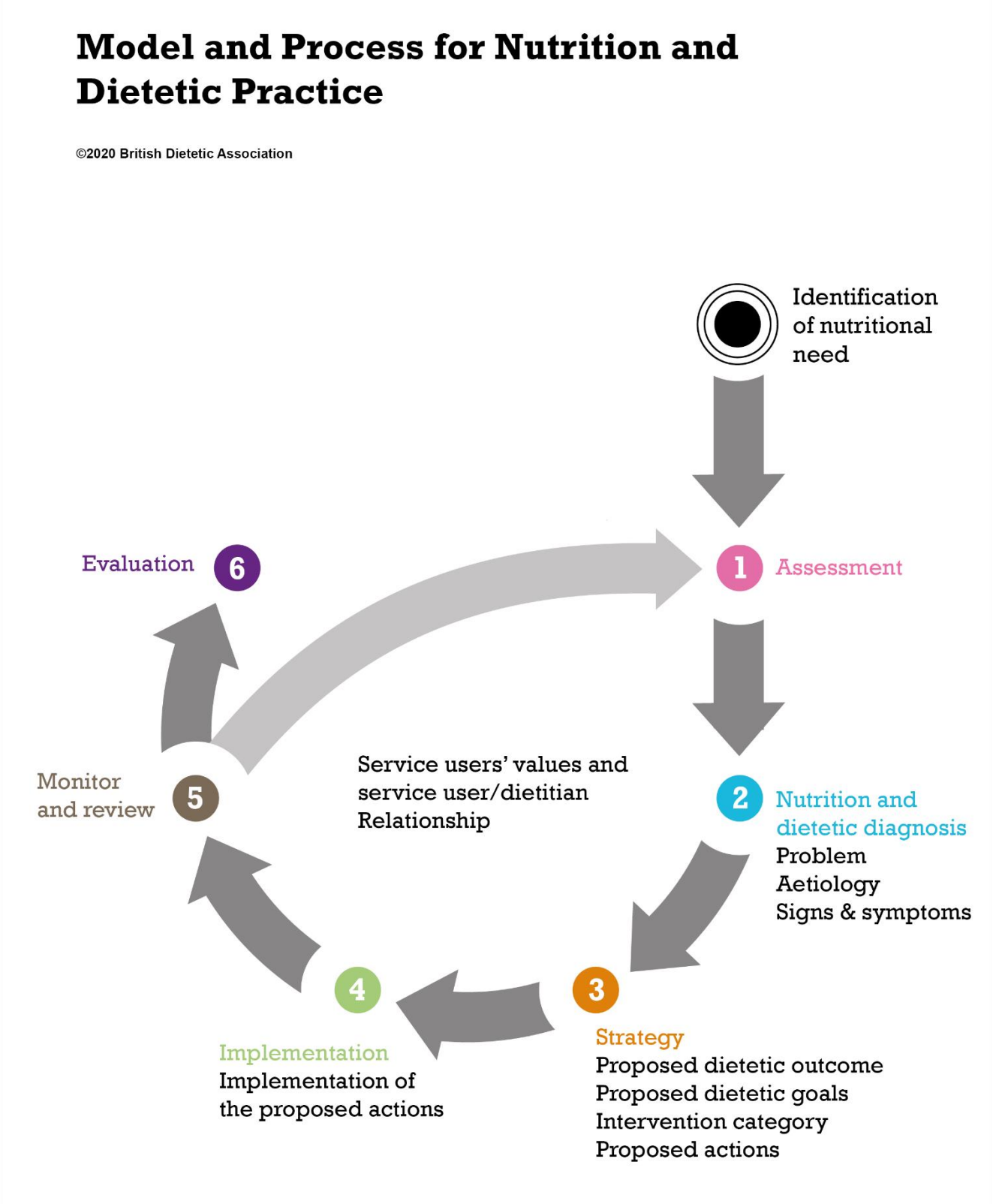

Figure 2: Model and Process
The Identification of Nutritional Need sits outside of the Model and Process. This need may have been identified by the individual, group or population requiring dietetic intervention or by a dietitian, another health professional, carer or organisation.

The six steps to the Model and Process

Step 1: Assessment – collect, analyse and interpret relevant information using critical reasoning to inform the dietetic intervention.
Step 2: Nutrition and Dietetic Diagnosis (NDD) – identify and prioritise nutrition problems, aetiology (causes), as well as signs and symptoms to be addressed. This is based on information from step 1 and is used to form PASS statement and document each 'problem' as a separate NDD.
Step 3: Strategy – define the outcome(s) (by the end of the intervention) and dietetic goals (by the next consultation) the dietitian and service user(s) aim to achieve. This stage also includes the intervention category and actions required to meet the dietetic goals.
Step 4: Implementation – define the communication, coordination, management and leadership required to effectively implement the actions and deliver the strategy.
Step 5: Monitor and Review – measure progress towards outcome(s) and goals as well as barriers and facilitators to progress. As you can see on the image above, the arrow here leads back to either assessment or evaluation - new issues or a lack of progress will lead to reassessment and possibly a new NDD, strategy and/or implementation.
Step 6: Evaluation – establish whether the outcome has been met, and the NDD resolved. Consider further action to be taken, research gaps and learning. Include comments and compliments.

An example of the Model and Process

1. Assessment

Collect data: A,B,C,D,E,F
Interpreted collected data to inform nutritional status and NDD

2. NDD

Identify PASS

- **Problem:** inadequate oral intake
- **Aetiology:** self-feeding difficulties and shortness of breath (COPD)
- **Signs and symptoms:** consuming <50% of meals eaten and recent weight loss of 5.5%

Construct NDD
Inadequate oral intake related to self-feeding difficulties and shortness of breath, as evidenced by consuming <50% of meals eaten and recent weight loss of 5.5%.

3. Strategy (jointly agreed with service user/carer)

Proposed outcome: improve inadequate oral intake to achieve 100% of nutritional requirements
Outcome indicator: estimated energy and protein intake
SMART dietetic goals: meet 50% of energy and protein requirements by next consultation
Goal indicators: estimated energy and protein intake
Intervention category: increased energy and protein diet
Proposed actions:

- Instigate red tray for additional support
- High-calorie, high-protein snack mid-morning
- High-calorie, high-protein meal choices

4. Implementation

- High calorie high protein food choices discussed with service user with practical suggestions to overcome self-feeding difficulties
- Information leaflet provided
- Service user will ask family to bring in snacks
- Discussed strategy with nurse in charge and healthcare assistant who will handover to all ward staff on ward round and instigate red tray system

5. Monitor and Review

Goal: Estimated energy and protein intake evidenced that 50% of energy and protein requirements have been met
Barriers: Problems with meal/snack provision
Facilitators: service user reports goal importance remains 9 out of 10 and confidence has increased from 6 to7 out of 10

6. Evaluation

Outcome: 100% of nutritional requirements achieved as evidenced by estimated protein and energy intake and stable weight – outcome met

Adequate oral intake so NDD resolved

Steps of the Model and Process

This section describes in detail the six steps of the Model and Process which can be used with individuals, groups or populations. It includes an explanation of each step, examples of information sources, as well as the critical reasoning and specialist skills employed by the dietitian. The descriptions are generic. The dietitian will choose, for example, the appropriate assessment data to collect.

Step 1 – Assessment

Assessment is a systematic process of collecting, grouping, analysing and interpreting relevant information to make decisions about nutritional status and the nature and cause of nutrition-related problems that affect an individual, a group or a population. The assessment demonstrates the critical reasoning that informs decisions made around the NDD as well as the development and monitoring of the intervention. Starting at assessment (during service user interview or patient and public involvement), and throughout the intervention, the service user's ideas, priorities, concerns and expectations should be integral.

The data collection prompt acronym (ADCDEF) may be used as a helpful tool to ensure that all appropriate data has been collected from relevant areas to help inform the assessment:
Anthropometry
Biochemistry
Clinical/physical,
Dietary,
Environmental/behavioural/social
Functional
You can find condition/disease-specific assessment information on the PEN system under the '[Practice Guidance Toolkit]' sections.

Collected data should be grouped and organised to clearly demonstrate the critical reasoning that informs decision making.

The specific information collected in the assessment will vary dependent on the practice setting, service user's health needs and expectations, and practice-based evidence and guidance. The assessment information will provide the baseline against which changes in health and the outcomes of the intervention are measured. These changes are captured by indicators, which measure progress against reference standards or baseline measurements.

Individual or Group

- Physiological measurement, anthropometrics
- Biochemistry and other lab results
- Health and disease status, especially in relation to consequences for nutritional status e.g. current medical problems and the progression of the disease or prognosis
- Medication, including over the counter medication and supplements. Concurrent treatment or interventions
- Nutritional and food intake
- Psychological and behavioural including readiness to change
- Knowledge and understanding of condition and impact on them now and in future. Social circumstances
- Functional measurements

Group or population

- Population/group knowledge, willingness to change and potential for changing behaviour
- Opportunities to effect change
- Population / group perceptions of health issues
- Identifying and assessing health conditions and wider determinant factors and associated risk to long term health
- Nutritional and food intake
- Physiological measurement, anthropometrics, biochemistry

Information sources

Individual	Group	Population
Referral information Laboratory tests Procedure results Multi-disciplinary records Information from other health and care team members Service user/carer interview Observation and examination	Referral information Pre-intervention questionnaires Community-based studies and focus groups Individual data sources (therapeutic groups) Population data sources (health promotion groups)	The service user's ideas, concerns and expectations Nutrition surveys Local health surveys Epidemiological studies Field activities: community-based surveys and focus groups Joint strategic needs assessment

Critical reasoning and specialist skills

- Comparison with standards
- Determining whether dietetic care will provide benefit for the service user
- Identifying which multidisciplinary health and care team members to consult
- Observing for verbal and non-verbal cues to guide and prompt effective interviewing methods
- Determining appropriate data to collect in different situations
- Find patterns and relationships among the data and possible causes
- Matching assessment method to the situation, for individuals, groups or communities
- Applying relevant assessments in valid and reliable ways
- Distinguishing important from unimportant data
- Validating the data
- Organising the data
- Problem solving
- Identify key partners and key workers and their role in the assessment process
- Determining whether the problem requires consultations with or referral to another health professional

Step 2 – Nutrition and Dietetic Diagnosis

The NDD is the identification of nutritional problem(s) to be addressed that may impact on the physical, mental and/or social well-being of an individual, group or population and where the dietitian is responsible for action. Firstly, a PASS statement is created, which is then formulated into the NDD.

This NDD may reflect:

- An existing nutritional problem which can be evidenced
- A potential nutritional problem, for example, when a medical intervention is likely to cause a nutritional problem
- Preventative or anticipatory care when a nutritional intervention has the potential to maximise health and prevent or manage deteriorations in health

Each nutritional problem is formulated into the NDD using the following three separate components (known as the 'PASS statement'):
Problem – identification of the key nutrition related problem(s) that the dietetic intervention will aim to address. Bear in mind the following question here: why is dietetic expertise required?
Aetiology – cause of the nutrition related problem(s)
Signs and **S**ymptoms – a cluster of signs and symptoms that evidence the problem

The NDD is written as: (problem) related to (aetiology) as evidenced by (signs and symptoms). See page four for an example.

The problem and aetiology both need to be within the scope of dietetic influence. If the dietitian cannot influence these, i.e. there is not a nutritional problem, or the aetiology is not within the scope of the dietitian, the service-user(s) would need to be referred to an appropriate practitioner that could support this.

You may address more than one nutritional problem. In such cases, these will need to be prioritised depending on:

- the severity of the problem
- service user, population and other stakeholder views on the problems
- perceptions of importance
- probability that intervention will lead to positive outcomes

Each problem should be documented separately to enable you to report on the outcome of whether each one was resolved.

Individual
An individual NDD requires therapeutic or educational action as determined by the dietitian and service user. It is based on scientific evaluation of physical and psychological signs and symptoms, dietary and medical history, procedures and test results and the priorities of the service user.

Group
In a therapeutic group, there will be an NDD for each individual in the group (as an individual). In a public health group, the NDD step will be the same as the population 'assessing a health priority for action.'

Population
Within a public health needs assessment framework, the NDD is assessing a nutritional health priority for action; choosing nutritional health conditions and determinant factors with the most significant size, impact and severity.

At all levels it includes the identification and categorisation of an actual occurrence, risk of, or potential for, developing a nutritional problem that a dietitian is responsible for treating independently or leading the strategy to manage.

Information Sources
The NDD will be formulated from the evidence presented in the assessment stage.

Critical reasoning and specialist skills
- Analyse assessment data to:
  - Prioritise the relative importance of problems to the service user
  - Prioritise the relative importance of problems for service user safety
- Make inferences ("if this continues to occur, then this is likely to happen")
- State the NDD clearly and succinctly, separately for each 'problem' that has been identified
- Being objective and factual (suspending judgement):
  - Make interdisciplinary connections
  - Rule in and rule out specific NDDs

Step 3 – Strategy

The strategy outlines what the dietitian and service-user(s) want to achieve, the indicators that will be used to measure this, and how they will achieve this. These provide evidence of improvement, or not, in nutritional or health status.

Proposed dietetic outcome – the dietitian and service user propose the outcome they are aiming to achieve by the end of the dietetic intervention. The outcome must relate directly to correct (resolve) the nutritional '**P**roblem' section of the NDD. More information on dietetic outcomes can be found on the BDA outcomes webpage.

Dietetic goals – the dietitian and service user decide on a set of SMART goals to be achieved by the next consultation. The goals enable monitoring of progress towards achieving the outcome, therefore they should relate directly to the proposed outcome. In situations where the service user has alternative goals to the dietitian ("'what matters to someone' is not just 'what's the matter with someone'" (6)), both the service user goals and the dietetic goals should be documented and monitored.

Indicators must be chosen for each outcome and goal; they must be able to measure change which can be compared against reference standards or a baseline. Standardised methods must be used where possible to increase the validity and reliability of measurements of change and to facilitate consistent recording, coding, and outcome measurements. Goal and outcome indicators may sometimes be the same. For example, if the proposed outcome is to achieve 5 percent weight loss by the end of the intervention, and the goal for the next appointment is 2lb weight loss, the indicator for both would be weight.

Intervention category* – the dietitian and service user agree on an intervention category which will meet the proposed outcome and goals. Example intervention categories include (but are not limited to): knowledge building, specialised diet, behaviour change, counselling, coordination of care, social marketing campaigns, food availability, food shopping and cooking skills.

***** *A list of categories can be found on the BDA outcomes framework under the 'codes' section.*

Proposed Actions – these are the proposed activities that should be carried out to meet the dietetic goals that have been identified. The evidence-base will be consulted to ensure the actions are based on best practice. The actions may be carried out or coordinated by the dietitian (or delegated to another health or social care professional), service user, carer, voluntary organisation and/or another member of the nutrition and dietetic team. Roles and responsibilities of those involved must be clearly identified and documented. Similarly to goals, actions should be SMART. The actions, together with the dietetic goals, will be reviewed and changed (as required) at each consultation until the outcome is met.

Information sources

- Service user or population perspective and priorities
- Assessment and NDD information
- Joint Strategic Needs Assessment
- Practice based Evidence in Nutrition (PEN)
- Evidence based guidelines or professional consensus such as professional guidelines or BDA professional guidance documents
- National Institute for Health and Care Excellence (NICE)/Scottish Intercollegiate Guidelines Network(SIGN)/Quality Improvement Scotland(QIS)/Guidelines and Audit Implementation Network (GAIN) or other national guidance or strategy
- Current research literature, such as meta-analysis, for example, Cochrane reviews and Campbell Collaboration
- Campaign and health improvement theories
- National and local health and social policy
- Results of audits
- Reflection and professional experience
- Public involvement strategies
- Provision of food
- Provision of nutrition support

Critical reasoning and specialist skills

- Evaluating the evidence-base and collaborating with the service user to prioritise and set outcome(s) and goals
- Selecting appropriate indicators for monitoring outcomes(s) and goals and using appropriate reference standards/baseline for comparison
- Choosing from among alternatives, the intervention category and actions needed to achieve the goals
- Prioritising, communicating and recording the actions

Step 4 – Implementation

This step requires the implementation of the proposed actions and the communication, coordination, management and leadership required by the dietitian to effectively deliver the strategy. The intent of this stage is to change nutrition related behaviours, risk factors, environmental factors or aspect of physical or psychological health or nutritional status of the individual, group or population. The dietitian must coordinate implementation of the strategy, deciding who is responsible for, and therefore who will manage, which sections. This is led by the dietitian, and communicated using the most appropriate platform to all of those involved.

The length, frequency and duration of the intervention will need to be defined. Resources may be needed. Risk management strategies will be applied as necessary.

Information sources

- Reflection and professional experience
- Behaviour change and educational theories applied at individual and population level
- A variety of current service user/group/population education materials in appropriate mediums including written or digital sources
- Teaching plans
- Social marketing materials

Critical reasoning and specialist skills

Critical thinking is required to determine which intervention category and actions are implemented on the basis of the assessment, NDD and the service users' ideas and priorities.

- Collaboration with service user, carers, care workers, other professionals, community, voluntary and statutory agencies
- Apply, and tailor, evidence-based approaches
- Education of service user and or other professionals in a variety of settings, using different techniques
- Behavioural change and dietetic counselling techniques
- Mentoring, education and supervision of others
- Problem solving
- Engaging partners and key workers
    - Identifying partners' key skills and how they contribute to the implementation
    - Making interdisciplinary connections
    - Making inter-organisational connections, including statutory, patient and voluntary groups
    - Initiating behavioural and other interventions
    - Matching intervention category and actions with service user or community needs, diagnoses, and values
- Specifying the time and frequency of care

- Facilitation and team building
- Coordination of dietetic care
- Developing opportunities for involvement
- Understanding of ethical and legal principles governing provision of care

Groups and populations

Community capacity building and project management

Step 5 – Monitor and Review

Monitoring refers to the review and measurement of the service user, group or population's nutritional status and/or dietary intake at planned intervals. This will be done by measuring progress towards outcome(s) and goals using specified indicators and evaluating any barriers and facilitators to progress. As you can see on the image above, the arrow here leads back to either assessment or evaluation - new issues or a lack of progress will lead to reassessment and possibly a new NDD, strategy and/or implementation.

This stage involves assessment of the following:

- Service user or group understanding, and adherence to, strategy and implementation
- Whether the current NDD is still appropriate, or a new NDD is now a higher priority
- Whether the current outcome, dietetic goals and actions are still appropriate
- Progress towards the dietetic goals through measuring change in goal indicators
- Whether actions are or are not improving or resolving the nutrition and dietetic problem, its aetiology and/or signs and symptoms
- Whether actions are being implemented as prescribed
- Barriers and facilitators to progress
- Whether to progress to the end of the dietetic intervention 'Evaluation', revisit the NDD, Strategy or, continue with current Implementation

The above should be modified accordingly to enable progress to be made. If there are new nutritional issues or lack of progress, a reassessment will be required and possibly a new NDD, strategy and/or implementation.

Information sources

The data collected should be appropriate, bearing in mind the outcome(s) and proposed goals.

- Service user records
- Anthropometric measurements, laboratory tests
- Questionnaires, surveys, symptom scales, pre and post-tests, knowledge evaluation (appropriate to NDD, strategy and implementation)
- Data collection forms, databases and software
- Service user, group or population surveys and feedback

Critical reasoning and specialist skills

- Reflecting on previous action
- Reflecting in action
- Transferring knowledge from one situation to another
- Determining which NDDs, goals and outcomes should be to prioritised at this time
- Evaluating where the service user/group is, in terms of proposed outcome and dietetic goals
- Explaining variance from expected outcome and goals

- Determining barriers and facilitators to progress
- Deciding between discharge/completion of dietetic intervention, continuation of dietetic intervention and/or reassessment

Step 6 – Evaluation

Evaluation is the systematic comparison of current findings against previous status. It represents the end of the dietetic intervention. Outcome indicators will be used to measure changes, to establish whether the proposed outcome has been met and whether this has resolved (corrected) the NDD.

This will either be a ‘yes’ or a ‘no’. If not met, the reason for this should to be evaluated. Any other positive/negative outcomes should also be documented.

This stage should identify what went well and not so well. Further action to be taken, research gaps and learning should be identified and communicated as necessary. Comments and compliments should also be documented.

Information sources

- Service user records
- Anthropometric measurements, laboratory tests
- Questionnaires, surveys, symptom scales, pre and post-tests, knowledge evaluation (as appropriate to diagnosis and intervention)
- Outcome tools
- Data collection forms, databases and software
- Service user, group or population surveys and feedback

Critical reasoning and specialist skills

- Evaluate whether outcome was achieved using appropriate indicators
- Evaluate and communicate variance from expected outcomes
- Determining factors that help or hinder progress
- Sharing of learning

Glossary

Action	A SMART (specific, measurable, achievable, relevant and timely) set of activities that should be carried out to meet the dietetic goal(s).
Dietetic goal	A SMART short-term aim which is set to be achieved by the next consultation. These should be informed by evidence-based practice.
Dietetic outcome	A measured change/resolution of the nutritional 'problem' at the end of the dietetic intervention. This could include, but is not limited, to health. For example, the problem could be knowledge or behaviour focused.
Dietetic intervention	The process of dietetic involvement from referral to evaluation.
Indicator	A variable used to measure change in the proposed outcome/goal, usually against reference standards or a baseline. Indicators should be validated where possible.
Intervention category	The type of intervention that will be used. The intervention category chosen will depend on the outcome(s) and goals to be met. Example intervention categories include, but are not limited to: knowledge building, specialised diet, behaviour change, counselling, coordination of care, social marketing campaigns, food availability, food shopping and cooking skills.

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Eleanor Johnstone (Chair) (Professional Practice Manager, British Dietetic Association)
Sue Perry (Deputy Head of Dietetics, Hull University Teaching Hospitals NHS Trust)
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Cystic Fibrosis Specialist Group
Diabetes Specialist Group
Food Allergy Specialist Group
Food Services specialist group
HIV Care specialist group
Oncology Specialist Group
Parenteral & Enteral Nutrition specialist group
Renal Nutrition specialist group

Further reading

BDA learning Zone: An Introduction to the Model and Process for Nutrition and Dietetic Practice – online course developed by the BDA to introduce the updated Model and Process

Practice-based Evidence in Nutrition PEN® – nutrition database providing evidence-based answers to practice questions. Practice Guidance Toolkits in PEN provide examples of PASS statements and Nutrition and Dietetic Diagnosis

NHS Education for Scotland - The Health Literacy Place – online tools and resources for healthcare professionals to support improved health literacy

NHS Health Education England - Educating and training the workforce - online tools and resources for healthcare professionals to support improved health literacy

COMET initiative - agreed standardised core outcome sets for certain conditions

Key questions to ask when selecting outcome measures: a checklist for allied health professionals – a checklist to assist individual AHPs and teams with selecting appropriate outcome measures.

References

1. The British Dietetic Association. A Curriculum Framework for the pre-registration education and training of dietitians. 2013 [cited 15 June 2020]. Available from: https://www.bda.uk.com/practice-and-education/education/pre-registration.html
2. Health and Care Professions Council. Standards of Proficiency – Dietitians. 2007 (updated March 2013) [cited 12 June 2020]. Available from: https://www.hcpc-uk.org/resources/standards/standards-of-proficiency-dietitians/
3. The British Dietetic Association. Nutrition and Dietetic Care Process. 2006 [archived].
4. Professional Practice Board of The British Dietetic Association. Model and Process for Nutrition and Dietetic Practice. 2016 [cited 15 June 2020]. Available from: https://www.bda.uk.com/practice-and-education/nutrition-and-dietetic-practice/professional-guidance/model-and-process-for-dietetic-practice.html
5. Alsop A, Ryan S. Making the Most of Fieldwork Education: A practical approach. Cheltenham: Chapman and Hall, 1996.
6. EFAD Professional Practice Committee. The importance of Outcomes Management in Dietetics Policy paper – EFAD Professional Practice Committee – 2020. 2020 [cited 26 June 2020]. Available from: http://www.efad.org/media/1973/policy-paper-outcomes-management_2020_04_15_formatted.pdf
7. The National Health Service. Five year forward view. 2014 [cited 15 June 2020]. Available from: https://www.england.nhs.uk/five-year-forward-view/
8. The National Health Service. The NHS long term plan. 2019 [cited 15 June 2019]. Available from: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
9. National Health Service England. Allied Health Professions into Action. 2017 [cited 15 June 2019]. Available from: https://www.england.nhs.uk/ahp/ahps-into-action/
10. The National Health Service. Next Steps on the NHS Five Year Forward View. 2017 [cited 15 June Nov 2019]. Available from: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

11. Writing Group of the Nutrition Care Process/Standardized Language Committee. Nutrition care process and model part I: the 2008 update. *J Am Diet Assoc*. 2008;108(7):1113-1117. Abstract available from: https://pubmed.ncbi.nlm.nih.gov/18589014/

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3rd Floor, Interchange Place, 151-165 Street, Birmingham, B3 2TA
email: info@bda.uk.com

bda.uk.com