



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 articulates the specific skills, knowledge and attributes that dietitians deploy, and the environmental factors that influence the practice of dietetics.



*Links to other documents are shown throughout in blue.

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 process of a dietetic intervention that facilitates professional practice.

In 2006, the BDA published the [Nutrition and Dietetic Care Process](#) to describe the process that brings together the knowledge, skills and attributes 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.⁽³⁾

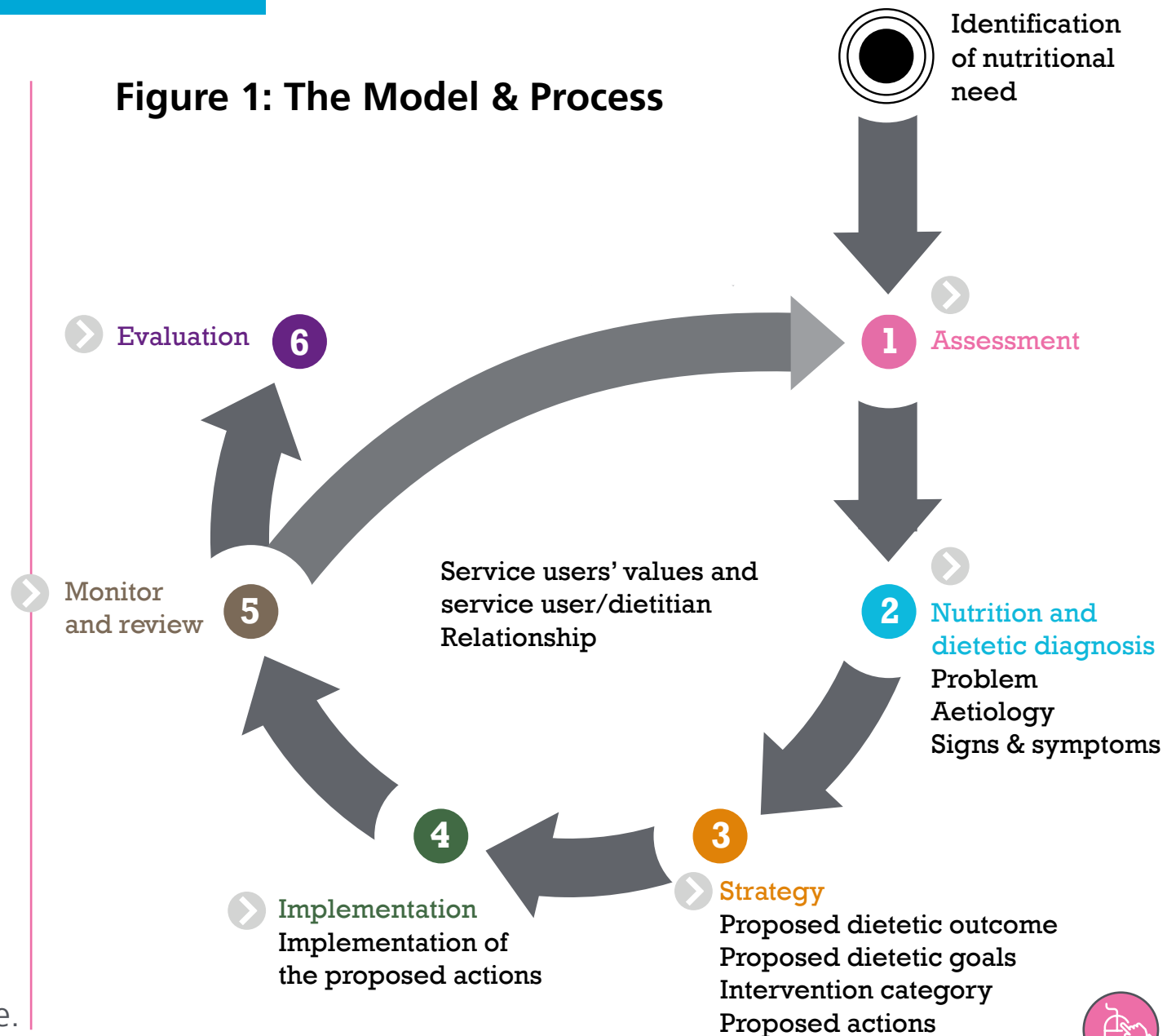
The Nutrition and Dietetic Care Process was reviewed in 2012 and renamed Model and Process for Nutrition and Dietetic Practice. This was then updated in 2016 by a working group of the BDA Professional Practice Board and then again in 2021 by the BDA outcomes working group.

Introduction

The Model and Process demonstrates how dietitians integrate professional knowledge and skills into evidence-based, critically reasoned, decision making using the six steps highlighted below. It describes the contribution of dietitians in different practice areas including clinical, public health, and health promotion, whether working with individuals, groups or communities.

At each step, the dietitian considers the evidence-base, makes decisions between assessment tools, establishes nutritional status, identifies and manages risks, identifies and prioritises aspects requiring action, decides on the problems requiring intervention and facilitates the most appropriate interventions. In this way, the Model and Process facilitates patient-centeredness and autonomy of practice.

Figure 1: The Model & Process



The Model and Process supports the dietitian with systematic, evidenced-based decision-making, while encouraging outcomes to be considered as part of this process in order to evidence the dietitian's contribution to care. A review of AHP public health outcomes.⁽⁴⁾ highlighted that a more standardised approach to outcome measures could result in better evidence of effectiveness. The standardised approach of the Model & Process provides an ideal framework for the generation and measurement of dietetic outcomes, which will enable the evaluation of data related to the effectiveness of practice and services at all levels.

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.^(5,6)

Measuring national-level outcomes has improved the quality of care in the NHS. For example we have seen improving cancer survival rates and declining heart attack and stroke death rates.⁽⁷⁾ 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.⁽⁸⁾

Application

Whether dietitians 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 development of 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

When describing and recording the steps of the Model and Process, standardised language should be used where possible. Using standardised language across the profession will enable us to collate and compare outcome data.

In order to facilitate this, the BDA has worked to translate electronic Nutrition Care Process Terminology (eNCPT) (an international dietetic specific terminology), into SNOMED CT and has published recommended terms for use in electronic records.

Application

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 (GDPR) as well as any relevant local/national policies.

An outcome-focused approach to recording dietetic diagnosis, strategy and implementation, supports clear communication between the service user, dietitian and other professionals as well as clearly directing the intervention. The service user's ideas, priorities, concerns and expectations should be integral to this approach. They should be considered together with the critical reasoning employed throughout the intervention, which should be clearly communicated. This structure should ensure a consistent quality of dietetic care for service users and employers.

The Model and Process is not a documentation process and as such it does not replace locally or nationally agreed record keeping standards and requirements. It should be integrated into locally agreed structures for documentation.

Layers of influence

No dietitian practices in isolation.

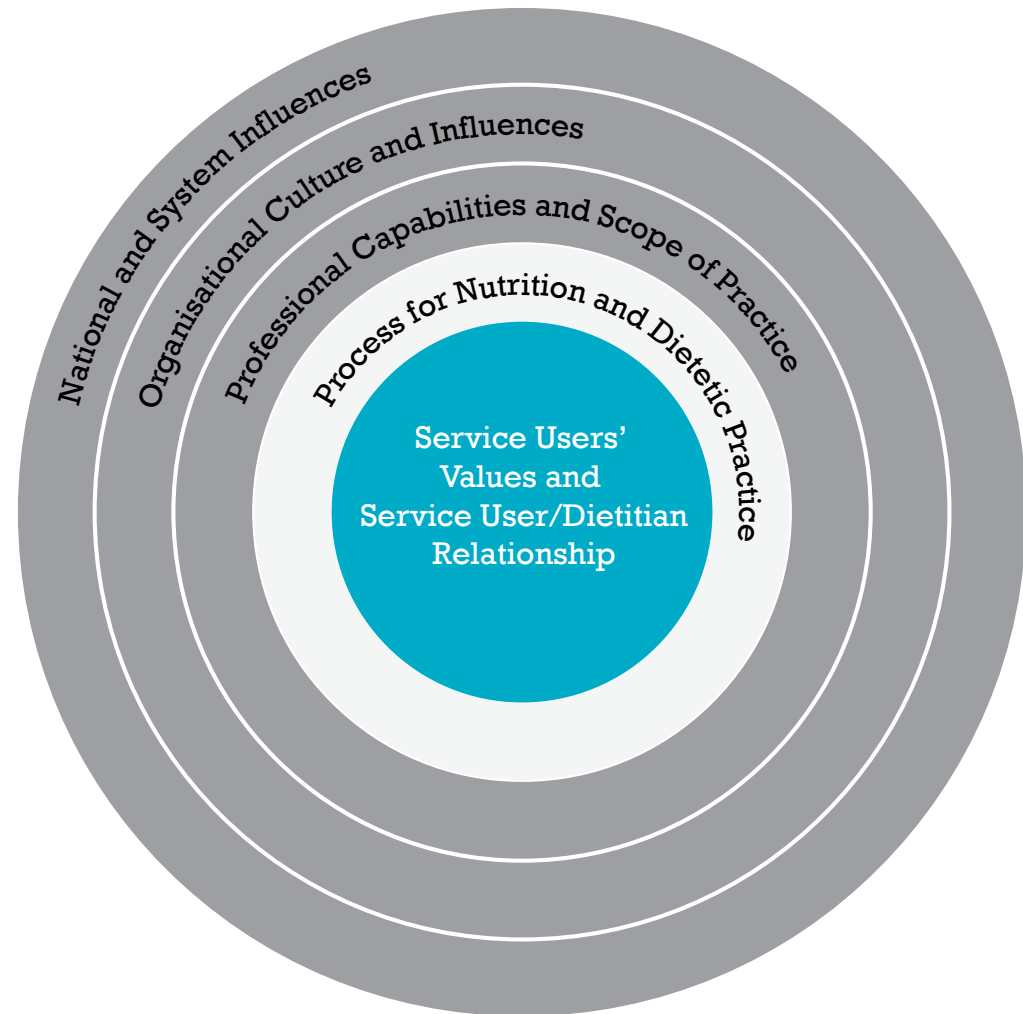
Figure 2 illustrates the layers of influence on the practice of a dietitian.

The immediate and most powerful influence is the relationship between the service user(s) and the professional.

Figure 2 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.

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.

Figure 2: Layers of influence



Layers of influence

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' ⁽⁹⁾

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. These in turn facilitate or constrain practice and shape, and are shaped by, the social systems.

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

The service user's ideas, priorities, concerns and expectations should be integral throughout the process.



1 Assessment >

Collect, analyse and interpret relevant information using critical reasoning to establish nutritional risk and inform decision making in future steps.

2 Nutrition and dietetic diagnosis (NDD) >

Identify and prioritise nutritional Problems, Aetiology (causes), as well as Signs and Symptoms (PASS) to be addressed using information from step 1. This is used to produce a PASS statement for each nutritional problem. Each PASS statement describes the specific NDD.

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 proposed actions required to meet the dietetic goals.

4 Implementation >

Define the communication, coordination, management and leadership undertaken to effectively implement the actions and deliver the strategy.

5 Monitor and review >

Measure progress towards outcome(s) and goals as well as barriers and facilitators to progress. As shown in Figure 1, the arrow 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.

6 Evaluation >

Establish whether the outcome has been met, and the problem resolved/improved. Consider further action to be taken, research gaps and learning. Include comments, concerns and compliments.

Steps of the Model and Process

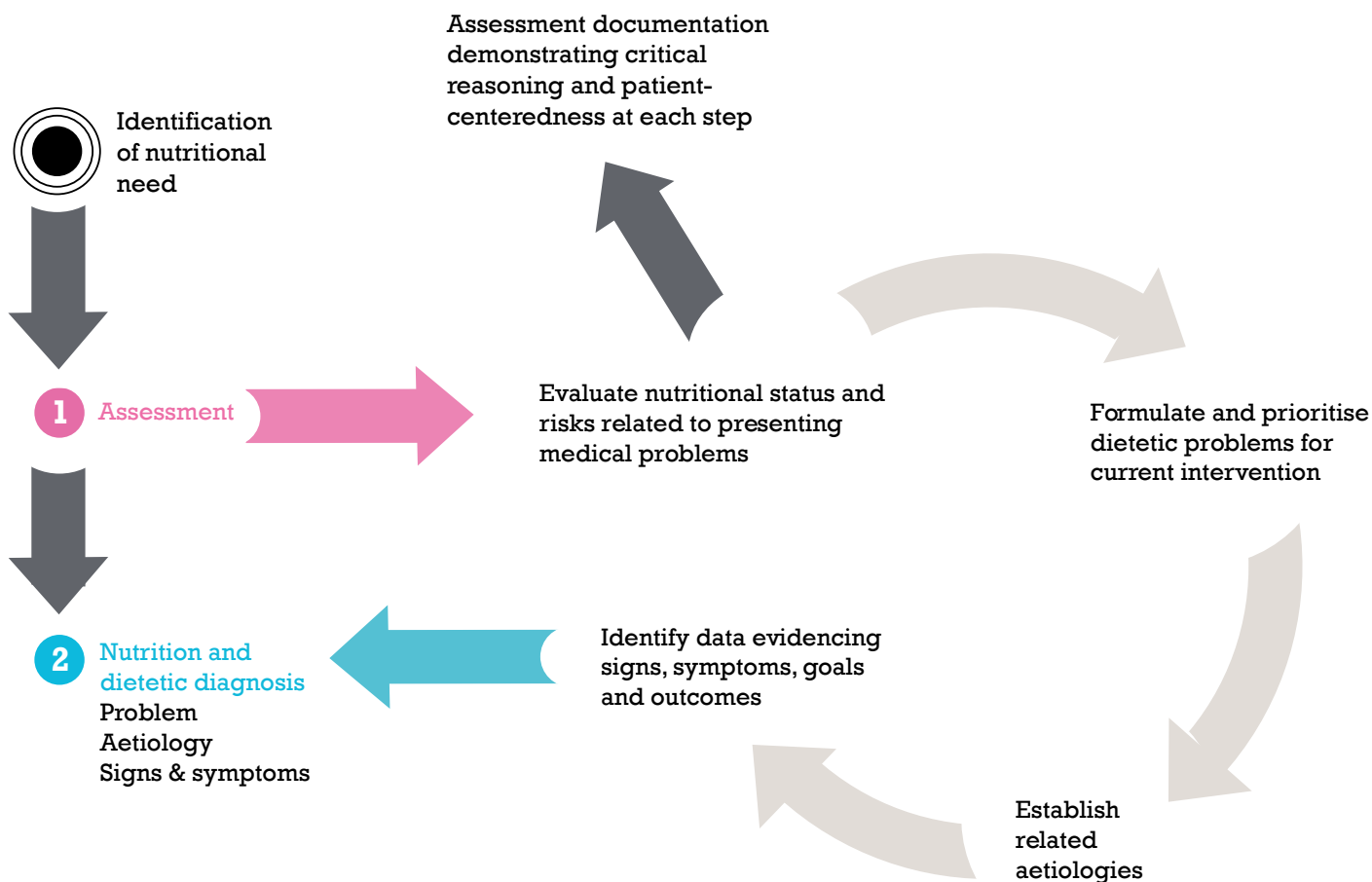
This section describes in detail the six steps of the Model and Process which can be used with individuals, groups or populations. It includes an explanation of each step, examples of information sources, as well as the critical reasoning and specialist skills employed by the dietitian. The descriptions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

1 Assessment

Assessment is an interactive process of collating, grouping, analysing and interpreting relevant information to make decisions about nutritional status and nutritional risk 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.

Figure 3: Assessment stage



The data collection prompt acronym (ADCDEF) may be used as a helpful tool to ensure that all appropriate data has been considered from relevant areas to help inform the assessment:

- A**nthropometry
- B**iochemistry
- C**linical/physical,
- D**ietary,
- E**nvironmental/behavioural/social
- F**unctional

You can find condition/disease-specific assessment information on the [PEN system](#) under the 'Practice Guidance Toolkit' sections.

Data that is deemed relevant 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 affect 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

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

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

2 Nutrition and dietetic diagnosis (NDD)

The NDD starts with the identification of nutrition related problem(s) to be addressed that may impact on the physical, mental and/or social health or well-being of an individual, group or population, that can be addressed and resolved by the dietitian.

This NDD may reflect:

- An existing nutritional problem which can be evidenced
Example: inadequate oral food intake for physiological needs due to self-feeding difficulties
- A potential nutritional problem, for example, when a medical intervention is likely to cause a nutritional problem
Example: predicted malnutrition due to being placed nil by mouth
- Preventative or anticipatory care when a nutritional intervention has the potential to maximise health and prevent or manage deteriorations in health. These include public health promotion programmes such as diabetes prevention programme
Example: predicted excessive energy intake due to incomplete food and nutrition knowledge

Each nutritional problem starts a NDD which is formulated 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 31 for an example.

The problem needs to be within the scope of dietetic influence. If the dietitian cannot influence this, i.e. there is not a nutritional problem, the service-user(s) would need to be referred to an appropriate practitioner that could support this. The aetiology may also be within the scope of dietetic influence and under these circumstances, the strategy should also aim to improve/resolve 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/relevance
- 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

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 'problem' 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'*⁽¹⁰⁾ 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 five 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 meet the dietetic goals that have been identified. The evidence-base will be consulted to ensure the actions are based on best practice. The proposed 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. 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

4 Implementation

This step denotes the implementation of the strategy and the communication, coordination, management and leadership required by the dietitian to effectively deliver the intervention. 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 the 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. Roles and responsibilities of those involved must be clearly identified and documented.

The length, frequency and duration of the intervention needs 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
- Application, and tailoring, of evidence-based approaches
- Education of service user(s) 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

5 Monitor and review

Monitoring refers to the review and measurement of the service user, group or population's nutritional status and/or dietary progress 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. The arrow leads back to either assessment or evaluation.

Please note that new nutritional issues or a lack of progress should lead to reassessment and may lead to a change in the 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 proposed 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 episode of dietetic care Evaluation, or revisit the NDD, Strategy or to 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

6 Evaluation

Evaluation is the systematic comparison of current status against the previous and represents the endpoint 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 problem in 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.

Further action to be taken, research gaps and learning should be identified and communicated as necessary. Comments, concerns 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

An example of the Model and Process

1 Assessment

- Identify/clarify dietetic needs
- Consider data from all sources: A,B,C,D,E,F
- Interpret relevant data to inform nutritional status, risk and dietetic problems.
- Organise data into a critically reasoned assessment

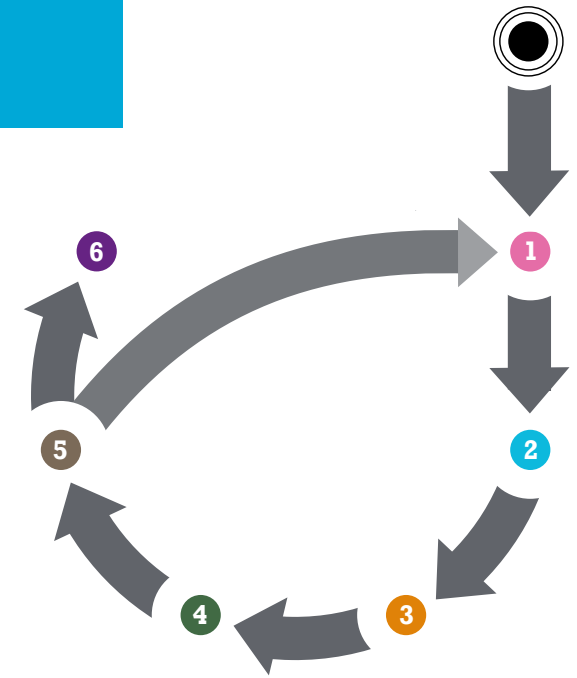
2 Nutrition and dietetic diagnosis (NDD)

Identify PASS

- **Problem:** inadequate oral food intake for physiological needs (SNOMED CT: 699653008)
- **Aetiology:** self-feeding difficulties and shortness of breath (COPD)
- **Signs and symptoms:** unintentional weight loss (448765001); decrease in appetite (64379006); poor grip strength (198281000000108)

Construct NDD

- Inadequate oral food intake for physiological needs related to self-feeding difficulties and shortness of breath, as evidenced by unintentional weight loss, decrease in appetite and poor grip strength



An example of the Model and Process

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

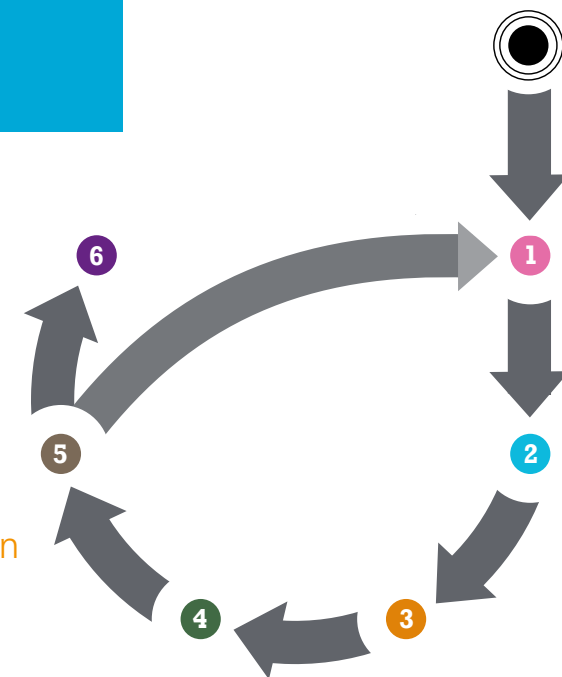
Intervention category: increased energy diet (436721000124103); increased protein diet (437461000124104)

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



An example of the Model and Process

5 Monitor and review

SMART Goal:

Estimated energy and protein intake evidenced that 50% of energy and protein requirements have been met

Barriers:

Problems with meal/snack provision

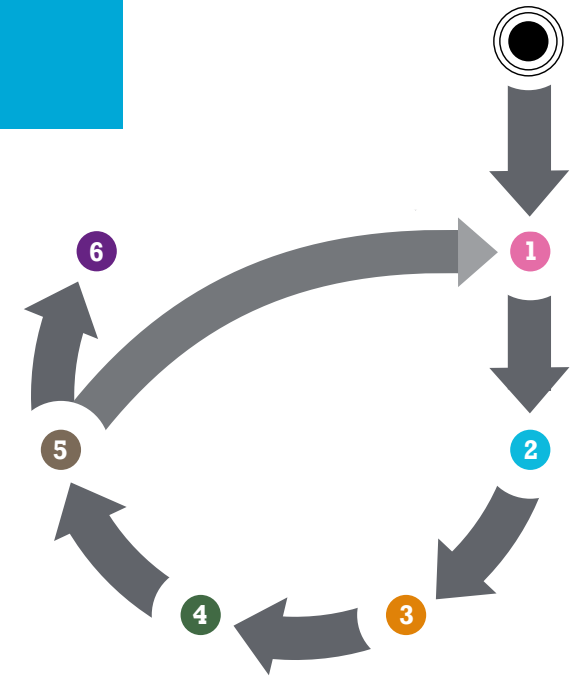
Facilitators:

Service user reports goal importance remains 9 out of 10 and confidence has increased from 6 to 7 out of 10

6 Evaluation

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

Adequate oral intake so NDD resolved.



Further reading

BDA learning Zone: An Introduction to the Model and Process for Nutrition and Dietetic Practice

An online course developed by the BDA to introduce the updated Model and Process

<https://www.bda.uk.com/practice-and-education/nutrition-and-dietetic-practice/professional-guidance/model-and-process-for-dietetic-practice/training.html>

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

<https://www.pennutrition.com/Toolkits.aspx>

NHS Education for Scotland - The Health Literacy Place

Online tools and resources for healthcare professionals to support improved health literacy

<http://www.healthliteracyplace.org.uk/>

NHS Health Education England - Educating and training the workforce

Online tools and resources for healthcare professionals to support improved health literacy

<https://www.hee.nhs.uk/our-work/population-health/training-educational-resources>

COMET initiative

Agreed standardised core outcome sets for certain conditions

<https://www.comet-initiative.org/>

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

<https://www.rcslt.org/outcome-measures-checklist/>

A

Term	Definition
Action	A SMART (specific, measurable, achievable, relevant and timely) set of activities that should be carried out to meet the dietetic goal(s).

D

Term	Definition
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, nutritional status or health. For example, the problem could be knowledge or behaviour focused.
Dietetic intervention	The process of dietetic involvement from referral to evaluation.

I

Term	Definition
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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