Malnutrition Care Plan Development

A. Responsible team member

- Dietitian

B. Definition

The development of a document outlining comprehensive planned actions with the intention of impacting malnutrition-related factors affecting patient health status[1]

C. Data sources/tools

1. Relevant clinical practice guidelines[1]
2. Current literature evidence base[1]
3. Local practice protocols
4. Patient/family caregiver interviews from assessment stage

D. Data to collect and record

1. Description of malnutrition care plan in patient medical record

E. Malnutrition Care Plan Steps

- Confer with patient and family caregiver to develop a malnutrition care plan specific to the patient's preferences (including food preferences), goals, needs, diagnosis, and values
- Any malnutrition-risk diet order issued following a malnutrition screening determining the patient to be "at risk" should be reevaluated based on the result of the nutrition assessment
- Work with all care providers and patient and family caregiver to formulate the malnutrition care plan Record the malnutrition care plan in the patient's electronic medical record
- Communicate malnutrition care plan to members of the patient's clinical Care Team (e.g. the patient's nursing team) via the most appropriate mechanism
- For each element of the malnutrition care plan, identify the appropriate Care Team member to complete and document relevant tasks. For example, a nurse will monitor and document intake changes, facilitate adherence, and reinforce education. Physicians include malnutrition diagnosis and care plan in daily problem list and discuss in team huddles
- Determine and document appropriate hand-off procedures among Care Team members and during changes in shifts
- Communicate the malnutrition care plan to the patient/ family caregiver and ensure the care plan goals
- are well understood
- Follow-up and monitor to ensure implementation of the malnutrition care plan, including coordination with primary care physicians and other providers who may interact with
- the patient following discharge from the hospital

F. Decision points for continuation of care

1. Specific actions outlined in the malnutrition care plan willbe specific to particular provider types as appropriate for execution

Best Practices

1. Malnutrition care plan should be developed by the dietitian (see Table 6)
2. Recommend hospitals grant dietitians ordering privileges to facilitate efficient care and timely interventions, if in accordance with state law (Note: This may require a physician co-sign)
3. Develop malnutrition care plan immediately following diagnosis (within 24 hours)
4. Engage patients and their family caregivers throughout the development and implementation of the malnutrition care plan where appropriate; i.e., patient should understand the goal of the components of the malnutrition care plan and how these play a role in recovery and healing
5. Design malnutrition care plan for execution by a multi-disciplinary team including dietitians, nurses, physicians, and patient and family caregiver[2]
6. Consider assigning different intervention care levels depending on the malnutrition risk to promote resource prioritization
7. Leverage EHR to standardize malnutrition documentation, facilitate malnutrition care plan, and build in alerts
   - Consider including a prompt in the electronic medical record to ask if a malnutrition care plan has been created when the patient malnutrition-related diagnosis is entered
   - Consider including a prompt (reminder) to reevaluate any malnutrition-risk diet order issued when developing the malnutrition care plan
8. The malnutrition care plan should support care efficiency by also being designed for incorporation into broader patient care plans[1]

The components highlighted in Table 6 are items that should be included in any malnutrition care plan developed by the dietitian. Users may print the table below to serve as a malnutrition care plan template or simply use the content to develop their own malnutrition care plans.

Table 6: Recommended Malnutrition Care Plan Components[ix]

Date and time stamp
Prioritization based on symptom severity
Clearly established goals developed in consultation with the patient and/or family caregiver
Goals and prescription that consider a patient's individualized recommended dietary intake
The prescribed treatment/intervention, which may include the following: a. Standard diet b. Specialized diet c. Oral nutrition supplement d. Liquid nutrition via tube feeding e. Parenteral nutrition f. Patient education g. Lab orders or culture assessments h. Physician consults or referrals i. Anthropometrics j. Physical activity (e.g., weight lifting) k. Suggested calorie counts
Identification of members of the Care Team
Timeline for patient follow-up, including recommendations for the attending physician regarding post-discharge planning

[ix] List of Recommended Malnutrition Care Plan Components provided by the Academy of Nutrition and Dietetics. Recommendations supplemented with findings from Avalere's best practices research.

SAMPLE PDSA Cycle: Malnutrition Care Plan Development and Implementation

Project: Malnutrition Quality Improvement Initiative
Objective of this PDSA cycle: Test the documentation and implementation of a malnutrition care plan for all patients age 65+ years diagnosed as malnourished

PLAN:

Questions: Will all patients age 65+ years with a malnutrition diagnosis have record in the EHR of a developed and implemented malnutrition care plan?
Predictions: All patients age 65+ years with a malnutrition diagnosis will have documentation in the EHR of a developed and implemented malnutrition care plan
Plan for change: Who, what, when, where
Enter in the EHR a malnutrition care plan and documentation that it has been initiated within 24 hours of documentation of malnutrition diagnosis for all eligible patients age 65+ years

- Following diagnosis, dietitian or qualified clinician will enter a malnutrition care plan for all eligible patients with a malnutrition diagnosis, including identification of the interdisciplinary Care Team. The role of the patient should also be clearly defined.
- Following documentation of the malnutrition care plan, members of the interdisciplinary Care Team will begin implementing it within 24 hours

Plan for data collection: Who, what, when, where

- Dietitian or qualified clinician documents the malnutrition care plan (i.e. treatment goals, prescribed treatment/ intervention) in the EHR
- Care Team members responsible for components of the malnutrition care plan document completion or stage of execution of various components in the EHR

DO:

Carry out the change: Collect data and begin analysis

- Conduct the assessment during a 24 hour period following the documentation of a diagnosis in the EHR
- Review EHR records for 15 eligible patients identified as malnourished
- Record results of date collected (e.g., components of the malnutrition care plan were not implemented for 3 out of 15 patients because Care Team roles were not clearly delineated)

STUDY:

Complete analysis of data

- Debrief: Discuss how to facilitate greater Care Team coordination and communication to ensure all elements of the malnutrition care plan are implemented. For example, could a member of the Care Team be designated to ensure that the roles and responsibilities of implementing the malnutrition care plan are communicated to all members?

Verify predictions

- How closely did the results of this cycle match the prediction that was made earlier?
- Summarize any new knowledge gained by completing this cycle. For example, documentation of the malnutrition care plan and Care Team roles and responsibilities in the EHR is not sufficient to ensure effective team coordination
- List actions to take as a result of this cycle
- Repeat this test for another 48 hours after providing clearer instructions to the Care Team regarding diagnosis details to be captured or after appropriate modifications have been made in the data collection processes in the EHR. Plan for the next cycle (adapt change, another test, implementation cycle): Run a second PDSA cycle for another 48-hour period.

ACT:

Identify actions

- List actions to take as a result of this cycle
- Repeat this test for another 96 hours after designating a Care Team member responsible for team communication. Plan for the next cycle (adapt change, another test, implementation cycle): Run a second PDSA cycle for another 96-hour period.