

Discharge Planning

A. Responsible team member

- All relevant Care Team members

B. Definition

Determines a patient's appropriate post-hospital discharge destination, identifies what is required to facilitate a smooth and safe transition from the hospital to the discharge destination, and helps to identify services and/or care a patient may need post-discharge in alignment with their nutritional and medical needs^[26]

C. Data sources/tools

- Patient's malnutrition diagnosis
- Patient's malnutrition care plan details
- Documented progress towards goals of the malnutrition care plan
- Biochemical data and medical tests
- Post-discharge nutrition re-assessment
- Patient and family caregiver interviews

D. Data to collect and record

- Note documentation of discharge
- Malnutrition-related components in discharge template

E. Discharge Planning Steps

Begin discharge planning 24 hours prior to the planned discharge

- Include malnutrition-related components of a discharge plan (e.g., malnutrition status, diagnosis, patient education on importance of malnutrition in overall recovery)
- Establish a follow-up appointment date and time for the patient
- Support implementation of the malnutrition care plan beyond the inpatient setting by:
 - Communicating the plan's key components and goals to the patient/family caregiver, and any other post-discharge provider or caregiver
 - Ensuring patient/caregiver has access to ongoing education to ensure understanding of malnutrition care plan
- Document all malnutrition-related components in the discharge template

F. Decision points for continuation of care

- The inclusion of nutrition-related components in the discharge plan is only necessary for those patients identified as at-risk or malnourished during the inpatient stay

Best Practices

- Create a designated space for nutrition information in the discharge planning template
- Tailor nutrition orders for discharge to the individual patient's needs and obtain input from all members of the Care Team
 - Include take-home information including malnutrition education and malnutrition care plan instruction materials that are in the patient's preferred language
 - Provide information directed to the patient and/or family caregiver related to best practices for self-management and links to community services; i.e., home delivered meals and Area Agency on Aging
 - Include a specific plan (e.g. specific appointment times for follow-up visits with the clinical Care Team) for monitoring and evaluating the patient's progress so that the patient's malnutrition care plan can be adjusted as necessary
 - Encourage patients to continue to work with their dietitian and offer information to help facilitate this relationship (e.g. ensure patients have appropriate contact information, etc.)
- Leverage EHR (when possible) to prepare discharge plan and coordinate care post-hospitalization
 - Include inpatient malnutrition diagnosis and nutrition intervention plan in the discharge summary. If possible via EHR linking, allow for auto-population of diagnosis into discharge plan
 - Create a template in the discharge summary that includes the patient's diet plan into the diet section of the summary
- Ensure appropriate policies and procedures are in place for patients lacking a support system outside of the hospital to facilitate effective and efficient discharge planning that is inclusive of malnutrition-related education and specific instruction

SAMPLE PDSA Cycle: Discharge Planning

Project: Malnutrition Quality Improvement Initiative

Objective of this PDSA cycle: Test the inclusion of malnutrition related components in the discharge planning for all patients age 65+ years diagnosed as malnourished

PLAN:

Questions: Will all patients age 65+ years with a malnutrition diagnosis have malnutrition related recommendations and orders included in their discharge plan?

Predictions: All patients age 65+ years with a malnutrition diagnosis will have malnutrition components included in their discharge plan

Plan for change: Who, what, when, where

Include malnutrition-specific discharge materials tailored to the individual patient in the patient's overall discharge materials for all eligible patients age 65+ years with a malnutrition diagnosis

- 24 hours prior to discharge, all members of the Care Team will provide input on the malnutrition components that should be included in the patient's discharge plan for all eligible patients with a malnutrition diagnosis, including care transition documents for the provider in the post-discharge setting

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

- All members of the interdisciplinary Care Team are eligible to provide documentation in the discharge template of malnutrition components (i.e. education materials) that should be included in the discharge plan SAMPLE PDSA Cycle: Discharge Planning

DO:

Carry out the change: Collect data and begin analysis

- Conduct the assessment during a 24 hour period prior to the discharge of patients with a malnutrition diagnosis
- Review EHR records for 10 eligible patients identified as malnourished
- Record results of data collected (e.g., malnutrition discharge planning materials were not provided for 2 out of 10 patients because there is no reminder system in place to alert the Care Team to the need to provide these materials)

STUDY:

Complete analysis of data

- Debrief: Discuss what kinds of reminder systems could be employed to help ensure the Care Team provides malnutrition discharge materials for eligible patients. For example, could a reminder system be incorporated into the EHR system to alert providers 24 hours prior to discharge that malnutrition discharge materials should be prepared?

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, the lack of a designated reminder system to alert the Care Team 24 hours before patient discharge that malnutrition discharge planning materials should be prepared and provided decreases the likelihood that these components will be included in the discharge materials

ACT:

Identify actions

- List actions to take as a result of this cycle
- Repeat this test for another 24 hours after providing modifications to the EHR system. Plan for the next cycle (adapt change, another test, implementation cycle): Run a second PDSA cycle for another 24 hour period