Discharge Planning

Patients who are identified to be malnourished (SGA B or C) and who do not fully recover their nutritional status during their admission, require ongoing care in the community. Health care teams should strive to provide a referral for ongoing nutritional treatment when rehabilitation of nutritional status is necessary. Health care teams need to provide the patient and family with community resources that can support their continued recovery in the community, for example, as list of meal programs, on-line grocery services, etc., that are available in the community.

> *"We need to show that we're actually making change, and helping patients, and keeping them out of hospital, and putting safety nets in place in the community. That's our job. I don't think that up to this point that I really realized that we could do all those things."*
>
> - Dietitian

Tips for developing a nutrition care discharge process

- Work with a team who is actively involved in discharge planning, e.g. discharge planner, social worker, hospital case manager for home care, nurse manager, occupational therapist, physical therapist, etc..
- Consult with other hospital health professionals to determine what they do for discharge planning. For example, occupational therapists may already be making recommendations about grocery shopping assistance or other services that can support food intake for the recovering patient.
- Meet with local/regional outpatient dietitians and health professionals in other facilities, primary care, and home care to identify community resources and discuss how referrals are currently made to their service and how this can be improved.
- Develop a list of services in your community that support food being accessible to patients; for example, meal programs (congregate dining where the patient goes to a location for the meal; meal delivery), grocery shopping and delivery, and food banks. Review this list on a yearly basis to keep it up to date. Provide phone numbers/locations and cost information.
- Develop a handout for patient/family members listing these community services, as well as general recommendations to encourage adequate food intake in the

community. This could also include signs and symptoms to watch out for, such as weight loss and poor appetite/intake.

- Discuss with your unit/hospital team how referrals can be made more consistently for patients leaving the hospital. Identify how communications can be improved (i.e., white board notes needed for referral at discharge; SGA status noted on the patient white boards; sticker on patient chart to note need for dietitian referral post discharge).

- Educate physicians who dictate discharge summaries to list the diagnosis of malnutrition.

- Educate Health Record coders to extract the diagnosis of malnutrition from the discharge summary and code using the appropriate ICD code for protein calorie malnutrition.