

Intervention Implementation

A. Responsible team member

- All relevant Care Team members

B. Definition

The implementation of specific actions outlined in the malnutrition care plan

C. Data sources/tools

1. Established malnutrition care plan
2. Relevant clinical guidelines
3. Current literature evidence base to help guide implementation best practices

D. Data to collect and record

1. Noted completion of each malnutrition care plan component in patient medical record

E. Intervention Implementation Steps

- Carry out patient care as outlined by the malnutrition care plan
- Continue ongoing communication of the malnutrition care plan to the patient/family caregiver, and all members of the Care Team.
- Collaborate with additional providers outside the original Care Team as necessary
- Engage with patient and family caregiver around actions they can take to support the malnutrition care plan
- Document completion of each element of the malnutrition care plan in the patient medical record

F. Decision points for continuation of care

1. Patient malnutrition care plan may be modified prior to discharge should the patient meet the goals of the initial care plan intervention
2. Modifications to the malnutrition care plan may also occur if the patient's medical condition changes or if the original plan is not meeting the patient's needs

Best Practices

1. Strive to begin implementation of the malnutrition care plan within 24 hours of diagnosis
2. Deliver food, oral nutrition supplements, or other malnutrition support to patient as soon as is feasible
3. Implementation of the malnutrition care plan should be a collaboration between all members of the Care Team
4. Modify malnutrition care plan (with the patient or family caregiver's input) as necessary depending on changes in condition and patient response to treatment. Document all modifications in the patient medical record
5. Include re-assessment in malnutrition care plan for patients who were diagnosed as "at risk" or malnourished at any point during their hospital stay if their last assessment did not occur within 24 hours prior to the discharge
6. Leverage EHR to standardize malnutrition documentation, integrate malnutrition care plan into broader care plan and build in prompts or reminders
7. Ensure patient safety, including communication of patient allergies, no conflicts between patient's feeding schedule and medication administration
8. Build nutrition intervention plan options into either the Diet line or Supplements line housed within the Diet Orders section of the EHR so clinician can select the most appropriate plan for the patient