Which data should we collect from nutritional counseling and therapy and how can we ensure these data are included in hospital discharge letters?[1]

Development of a structured documentation concept to facilitate the integration of nutrition-related patient data into discharge management – a case study

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Abstract

Documenting dietetic data in a structured way so that it can be integrated into mandatory discharge management is a challenge for hospitals. This study developed a documentation concept for the data that is to be documented in nutritional counseling and therapy, taking process-guided working methods into account, and compared it with current practice in a case study. The target/actual comparison shows that current documentation is unstructured and incomplete due to a lack of structural resources and personnel, and due to a lack of an implementation strategy. The study identified necessary adjustments and recommendations for action. The documentation concept represents a decisive step forwards in terms of expanding the discharge letter to include dietetic data. Further studies on implementation in practice are needed.

Keywords: Nutritional therapy, Dietetic Care Process, documentation, discharge management, interprofessional interface management

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Background

On October 1, 2017, the Framework Agreement on Discharge Management, which is legally binding for hospitals under Section 39 (1a), Volume V of the German Social Security Code (*Fünftes Buch Sozialgesetzbuch* – SGB V), came into force. This agreement sets out requirements for "patient-specific, resource-oriented and participation-oriented" [1] discharge management during the transition to post-hospital care and aims to ensure that care is needs-based, continuous, and consistent across sectors. The agreement provides follow-up care providers, including those in dietetics, the opportunity to continue providing therapy in an effective and efficient way [1].
The discharge letter, which is key to discharge management, should contain all the information required for the patient's further treatment and follow-up care. In particular, it should document all of the treatment data collected from the various professional groups involved in the treatment process. Nutritional therapy services carried out in the hospital should therefore also be included in the discharge letter. Section 9 of the Framework Agreement on Discharge Management, "Documentation to be provided to the physicians providing further treatment", specifies the minimum information that is required, however the lists of requirements are to be understood as overarching, interprofessional

[1] This article is based on a poster that was presented at the 58th Scientific Congress of the German Nutrition Society in February 2021.

requirements and they do not specify exactly which dietetic data should be documented [1].
Berger et al. provide one possible approach to this documentation. They developed a documentation tool in the context of an international Delphi study. The tool specifies which specific nutrition-related data should be recorded and forwarded to different health care facilities [2].
Following on from the study by Berger et al., the aim of the present article was to define in detail what the hospital should document in the context of nutritional counseling and therapy. This was defined using a process-guided approach in order to yield a documentation concept that would ensure that meaningful dietetic data can be incorporated into discharge management.

Methodology

Using a structured literature review within the NCBI PubMed database and a manual search via Google Scholar, further studies published in the last ten years were searched for using the keywords ESPEN European Society for Clinical Nutrition and Metabolism, discharge letters, discharge reports, nutritional care processes, nutritional documentation, patient discharge, standardized terminology. Only studies that dealt with the development of a documentation concept were included.
As the basis for creating the documentation concept, the definitions and operationalizations of the process steps of the Dietetic Care Process (DCP) (◆ Table 1), which five universities jointly

	Allocation	Central statement	Aims and principles	Operationalization
Dietetic Assessment	First step of the DCP	It is a systematic process to gather dietetically adequate and relevant information about the client by using state of the art methods.	Identifying nature and cause of dietetic related problems of the client.	The gathered information are documented in types of categories (client history, diet history, behavioral-environmental, clinical status) or following the ICF-model.
Dietetic Diagnosis	Second step of the DCP	Description of existing dietetic problems or risk for developing them.	Expressing dietetic related problems by formulating statements about Problem P, Aetiology A, Signs/Symptoms S and Resources R.	The PASR-statements are phrased in the following way: specific dietetic problem RELATED TO aetiology AS EVIDENCED BY signs (objective) and symptoms (subjective). For treatment usages, the resources … can be used.
Planning Dietetic Intervention	Third step of the DCP	Development of a dietetic intervention plan by setting goals and determining the strategy to solve the dietetic problems.	Developement of an intervention by changing identifiable outcomes in collaboration with the client and other health professionals. All activities are planned with respect of resources.	The dietetic intervention plan consists of defined and agreed treatment goals, type of intervention, process and outcome indicators and limitations.
Implementing Dietetic Intervention	Fourth step of the DCP	Client-centred approach to support and monitor the intervention and adherence of the client.	Solving the identified dietetic related problems by implementing the intervention plan, monitoring of the intervention progress and modifying the intervention if necessary.	The client is supported to implement the specific arrangements according to the dietetic intervention plan. The client's progress and the adherence are monitored.
Dietetic Outcome Evaluation	Fifth and last step of the DCP and can be linked to a further assessment and/or the other steps of the DCP.	The predefined systematic and structured approach to analyze the outcome of the implemented dietetic intervention at a defined point of time.	Evaluating the success of the planned and implemented dietetic intervention and to which extend the dietetic related problem is solved.	The predefined outcome indicators are assessed. The outcome will be evaluated by comparison with corresponding assessment information and reference standards.

Tab. 1: **Overview of the process steps of the Dietetic Care Process (DCP) as well as their definitions and operationalization** [4]
ICF = International Classification of Functioning, Disability and Health

developed within the framework of the EU project Improvement of Education and Competences in Dietetics (IMPECD), were used in addition to the study by Berger et al [2]. The term "client" is also used to refer to patients in the inpatient setting [3, 4]. These definitions have been chosen primarily to allow an in-depth focus on monitoring and on Dietetic Outcome Evaluation when assessing the effectiveness and efficiency of nutritional counseling and therapy [5]. They are intended to reflect the strengthening of European cooperation in education and professional practice through the use of a common process model [6]. The DCP is currently being tested and implemented in practice in a participatory manner in the "model project for dietetic care in the Fulda area" ("*Modellprojekt für die diätetische Versorgung im Raum Fulda* [MoDiVe]"), and it is therefore also being used for this case study. However, the focus in this case study is on a process-guided approach, as set out in the German-Nutrition Care Process (G-NCP), which is recommended by the German Association of Dietitians (*Verband der Diätassistenten – Deutscher Bundesverband* [VDD]) [7]. The data that is to be documented for each of the process steps was summarized in a table.

The research results from the literature relating to the documentation concept that was to be developed were compared with the operationalizations of the DCP process steps (◆ Table 1). Aspects of the studies that did not correspond to any DCP process step were instead examined with regard to the legal requirements of the Framework Agreement on Discharge Management [1] and with regard to quality assurance aspects of dietetics defined by the Coordination Group for Quality Assurance in Nutritional Counseling and Education *(Koordinierungskreis Qualitätssicherung in der Ernährungsberatung und Ernährungsbildung)* [8]. If relevant to dietetic work, these aspects were integrated into the documentation concept. To ensure that responsibilities were transparent, each type of content within the documentation concept had the professional group responsible for documentation assigned to it.
Next, the hospital's previous documentation that was identified as relevant in the course of the research was reviewed (analysis of current state). These documents reviewed were paper-based documentation templates and printouts such as discharge letters, documents regarding in-house screening for malnutrition, dietitian's requirements/consultation, surgical history sheets, and allergy sheets. In addition, excerpts from digital documentation by dietitians, nurses, and physicians were added as photographs and included in the review.
The document analysis compared the current methods of documentation with the documentation concept that was developed. The aim of this target/actual comparison was to identify which data defined as relevant were already being documented at the hospital. Based on the results of this document analysis, deficiencies were identified and discussed. Finally, recommendations for action in terms of the implementation of the concept were identified.

Results

Documentation concept

The documentation concept that was developed as a result of this process includes self-reported information from patients as well as objectively measured values, all organized according to the five process steps of the DCP [4, 9]. In the first step of the development of the documentation concept, content that had not previously been taken into account was added to the operationalizations of the DCP, as recommended in the International Classification of Functioning, Disability and Health (ICF) [10, 11]. These additions included characteristics such as breastfeeding and, in the behavior and environment category, experience with prescribed diets and willingness to change previous dietary behavior. In the clinical status section, metabolic parameters in blood and urine were added [5, 12].
Screening for malnutrition, which is one of the triggers for referral to nutritional counseling and therapy when malnutrition is present (or there is a risk) [13], was added to this extended basic structure based on the operationalizations, in accordance with the contents of the studies researched by Berger et al [2], Cederholm et al [13], and Kergoat et al [14]. Detailed recording of artificial nutrition was also added. ◆ Table 2 provides a summary of the documentation concept that was developed.

The fact that responsibilities are allocated makes it clear that dietitians are responsible for collecting and documenting actions taken in the context of process-guided working methods in dietetics [8]. According to the German Network for Quality Development in Nursing (*Deutsches Netzwerk für Qualitätsentwicklung in der Pflege* [DNQP]), screening for malnutrition upstream of the DCP in the documentation concept is the responsibility of nurses [15]. Data from Dietetic Assessments, such as personal, anthropometric data or data on physical signs and symptoms, are collected not only by qualified dietitians but also by nurses and physicians, resulting in an interprofessional interface here [16].

Analysis of documents

The target/actual comparison between the documentation concept and the hospital's current documentation practices showed that screening for malnutrition was performed in a paper-based manner by various professions using the hospital's own questionnaire, which is

Content of the documentation concept
Screening for malnutrition (identified risk for malnutrition as possible point of entry into the DCP)
Step 1: Dietetic Assessment
Client History
Personal history
Medical/health history of client family
Diet History
Eating habits (meal and snack pattern)
Fluid intake and fluid balance
Energy intake, energy expenditure and energy balance
Food and nutrient intake as well as food and nutrient balance
Food and nutrient administration/food recommendations/requirement for prescribed diet (incl. artificial nutrition)
Medications including over-the-counter medication and supplements
Behavioral/Environmental
Food and nutrition knowledge beliefs and attitudes behavior
Behavioral factors, willingness to change and potential for changing behavior
Factors affecting access to food and food/nutrition-related supplies
Physical activity and function: nutrition related activities of daily living
Quality of life
Clinical Status
Anthropometric data
Body composition
Biochemical data, medical tests, and procedures
Nutrition-focused physical findings (e.g. such as chewing and swallowing disorders)
Step 2: Dietetic Diagnosis
PASR[a] statements
Step 3: Planning Dietetic Intervention
Ranking the PASR statements in order of priority
Define interventions based on the best available scientific evidence
Patient's resources
Defining the objectives of nutritional therapy (precise objectives)
Intervention plan
Establishing the parameters of monitoring
Establishing the parameters for dietetic outcome evaluation
Recording of any adverse signs or symptoms
Defining responsibilities for the implementation of aspects of the intervention
Step 4: Implementing Dietetic Intervention
Individual intervention
Monitoring (following up on the progress of nutritional therapy and the patient's adherence to the therapy)
Step 5: Dietetic Outcome Evaluation
Outcome indicators
Assessment of whether goals have been achieved

Tab. 2: **Structured documentation concept for the hospital in the case study**
[a] The British English term *"aetiology"* has been used in the acronym PASR (problem, aetiology, symptoms, resources); this was explicitly agreed upon in the European project Improvement of Education and Competences in Dietetics (IMPECD).

based on the scientifically recognized screening tool Nutritional Risk Screening (NRS 2002) [17] and on the Subjective Global Assessment (SGA) [18]. Structured interface management was evident in the hospital's approach. The hospital's paper-based screening form contains sections (NRS 2002) that are to be completed by nurses (initial screening) or dietitians (main screening) and sections (SGA) that are to be completed by physicians, making it very susceptible to errors when it is used in practice. The document was not clear about how to transition into Dietetic Assessment when there is a risk of malnutrition.

Certain aspects of the Dietetic Assessment were not recorded as standard at the hospital. This applied in particular to data in the categories of nutritional habits and behavior and environment. In the hospital of the case study, no internally standardized assessment sheet for dietary data is used by the dietary staff. Data collected by nurses or physicians that were relevant to the Dietetic Assessment were documented as standard in the documentation excerpts examined. Neither the Dietetic Diagnosis nor the Planning Dietetic Intervention was documented. The implementation of the dietetic intervention was partially documented. The documentation described the services provided, but it did not document any monitoring parameters, even though the relevant process models require this. The documents did not include any record of a review of whether the objectives had been achieved being carried out as part of the Dietetic Outcome Evaluation.

◆ Figure 1 shows the documents that were assessed as part of the document analysis in the case study, along with the corresponding responsibilities.

Discussion

The documentation concept developed in this case study, which is based on the process model DCP, also takes the results of previous screening for malnutrition into account [4, 13]. It is compliant with the legal requirements of the Framework Agreement on Discharge Management and it meets the quality assurance requirements of the Coordination Group for Quality Assurance in Nutritional Counseling and Education [1, 8].

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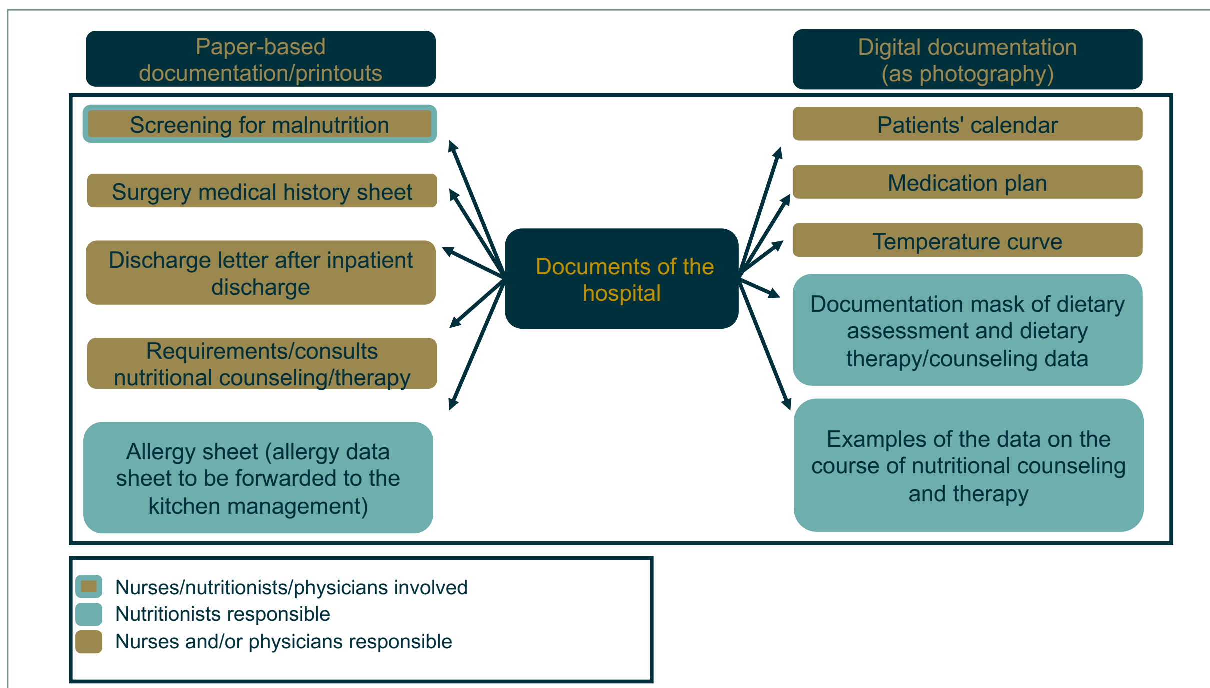

Fig. 1: **Documents included in the case study for document analysis and allocation of responsibilities**

The target/actual comparison shows that in practice, the hospital examined here is not yet recording some essential elements of the documentation concept in a structured manner and that the provided dietetic services are not very clear from the documentation. As a result, at present, there is little documented dietetic data available that can be incorporated into the hospital's discharge management system.
Reasons for this – which are also described in the literature – may include structural deficits such as a lack of an implementation strategy, a shortage of human resources, and limited facilities for electronic documentation [19].
The case study found that the way screening for malnutrition is currently performed at the hospital is not yet in line with internal guidelines. This could be due to incomplete implementation of the allocation of responsibilities and incomplete implementation of processes in the area of interface management between nursing staff, dietitians and physicians at the hospital. Studies on the implementation of malnutrition screening in practice have shown that both a lack of personnel and time, as well as imprecisely defined responsibilities and a low level of awareness of the problem of malnutrition among nurses and physicians make it difficult to implement malnutrition screening [20].
The data analysis on nutritional counseling and therapy conducted in the case study shows that the digital documentation template available to the dietitians at the case study hospital offers only limited structural scope for documenting information across all steps of the process. However, it should also be noted that due to the limited period of time patients spend in hospital [21], there is often no time to complete all of the individual process steps in nutritional counseling and therapy in hospital and therefore it is not always possible to document them. This makes the interface with those providing follow-on nutritional counseling and therapy after discharge from hospital all the more important [22].

Legally binding documentation requirements for nutritional counseling and therapy, similar to those in place for nurses and physicians [23], could make a decisive contribution to more comprehensive documentation of dietetic data. In the meantime, coordinated, unified documentation concepts in the form of standard operating procedures could provide a useful basis for documentation. Documentation about the process model that has been implemented can improve the documentation of dietetic data [6].

Deriving recommendations for action from these results

The recommendations for action at this hospital – presented in ◆ Overview 1 – that were derived from the results are intended as a stimulus for other hospitals as well. They take into account the responsibilities of dietitians, especially with regard to the structured implementation of a process model for the nutritional counseling and therapy in terms of process-guided working methods and interface management. To ensure adequate documentation, the digital documentation template that the dietitians use needs to be adapted in line with the revised documentation concept and the process steps that have been implemented. One key element of this is the creation of a digital assessment sheet that covers the dietetic data required in accordance with the documentation concept. This digital assessment sheet is intended to be used in a standardized manner.

Overview 1: General recommendations for action for the implementation of a structured documentation concept

1) Interprofessional discourse should reflect and establish greater awareness and a shared understanding of how the various steps of nutritional counseling and therapy should be structured based on a process model.
2) The existing digital documentation system should be expanded to include a data entry template for the data collected from dietetics (in accordance with the documentation concept) and the evaluation routines should also be expanded.
3) Dietitians should receive training in how to put the documentation concept into practice
4) The documentation concept should be tested and evaluated, any "stumbling blocks" should be identified and corresponding solutions should be developed.
5) Interface management between the various professions should be improved.
6) The data documented in the course of nutritional counseling and therapy should be incorporated into the discharge letter.

If necessary, dietitians should be trained with regard to the steps involved in the process-guided working method and in particular with regard to the operationalizations so that they can perform and document the relevant actions. Subsequent automated transfer of the structured dietetic data will allow the data to be integrated into the discharge letter, thus ensuring that it can be forwarded to subsequent care providers.
After the documentation concept has been implemented and integrated into discharge management, an evaluation will need to be performed in order to check its suitability for use in everyday practice.

Limitations

The documentation concept that has been developed is based on scientific models and is to be understood as theoretical construct for the time being. Its suitability for use in routine practice at the hospital still has to be verified. A further limitation of this study is that only a limited selection of the hospital's documents that were identified as relevant on the basis of the preliminary work could be included in the document analysis (analysis of current state) for the case study. A more comprehensive review of all documentation at the hospital, as well as additional qualitative interviews of staff members from various professions, would have yielded more detailed results. It is not possible to draw general conclusions from this study due to the fact that the research was carried out in the form of a case study.

Conclusions

The documentation concept that has been developed clarifies which data from nutritional counseling and therapy needs to be documented. The documentation concept includes self-reported information from patients as well as objectively measured values organized according to the process steps of the DCP.
It is also a structured template that other hospitals can also use and base their own target/actual comparisons on.
The implementation of this documentation concept, which is based on process-guided working methods, is an opportunity for hospitals to integrate defined and relevant dietetic data into discharge management in a structured way.
Future studies investigating the transfer of data will have to provide the necessary evidence for this – this will also be necessary for any subsequent theses. It can be assumed that the dietetic services provided can be made much more transparent by implementing electronic documentation concepts based on process models. This may also reveal what the outcomes of the nutrition therapy interventions are. Structured documentation makes a significant contribution to quality improvement. It is also anticipated that the quality of care, both during hospitalization and across sectors, could benefit significantly from the implementation of a documentation concept and from its integration into discharge management. To enable cross-sectoral use of dietetic data in the future, data from nutritional counseling and therapy originating from outpatient care or other inpatient facilities must also be made available when patients are admitted to the hospital.

Conflict of Interest
The authors declare no conflict of interest.

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