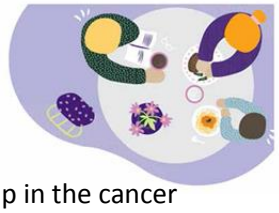

Nutrition discharge planning checklist:

Transitions of care are time-points when healthcare moves between settings and/or from one step in the cancer path to the next. It can involve changes to the healthcare team, the nutrition focus or dietitian involved.

Appropriate clinical handover is essential for optimal and safe transfer of nutrition care.

Dietitian tips – to ensure optimal nutrition care is met during transitions of care:

- ✓ Review patient list daily to cross-check who is no longer an inpatient – for acute based transfer of care, complete ISBAR handover in a timely manner
- ✓ Attend team meetings and ward huddles to participate in discharge planning
- ✓ During initial assessment – make a plan for ongoing nutrition care with the person with cancer and their carer
- ✓ Follow up any person with cancer who fails to attend an outpatient appointment (as per your policy)

TIP!

Check out the 'finding a dietitian' factsheet for further details (www.petermac.org/CanEATpathway)

TIP!

Review the decision support tools for help in navigating nutrition care for people with cancer

Dietitian to consider the following:

- ➢ Discuss nutrition goals with the person with cancer/carer prior to discharge
- ➢ Consider options for changes in nutrition care and discuss these with the person with cancer/carer (for e.g. referral to community health/rehabilitation) with respect to;
  - Type of service – 1:1 appointments, group sessions
  - Location of service and proximity to home
  - Home visit service options
  - Service fees/costs
  - Service integration – ability to access multiple allied health services within one location
- ➢ Communicate plans for referral to community-based services within the multi-disciplinary cancer care team;
  - For people with cancer ≥ 65 years of age, discuss early My Aged Care (MAC) registration to avoid delay in access to follow up care
  - For rural/regional people with cancer – refer early so support can be obtained during and after treatment
- ➢ Complete the 'Nutrition Prescription' – provide written information and contact numbers for both the current and proposed setting providing the nutrition care
- ➢ Check nutrition information is included in the person with cancer's medical discharge summary, including the need for nutrition monitoring
- ➢ Where on-going dietetic intervention is indicated – send a copy of the nutrition discharge summary/nutrition handover to person with cancer's GP, including how they can monitor the person with cancer and what to do if the situation worsens

TIP!

Use relevant 'nutrition step' factsheet to discuss nutrition goals (www.petermac.org/CanEATpathway)

TIP!

Some health services may have a cancer link nurse to support the transition of ongoing nutrition care