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Junior Dietitian-Led Malnutrition Training for Nursing & Healthcare Staff

A model for wider implementation?

What is known already

There is a growing understanding of the need for multi- and inter-disciplinary approaches to champion nutrition care within the clinical setting. To provide quality nutrition care, healthcare professionals need to develop adequate knowledge to increase capacity and confidence. Despite this, it is well documented that there is insufficient exposure to nutrition in healthcare education across numerous settings (Lepre *et al.*, 2022).

Having noticed this gap in training being further impacted by the onset of the COVID-19 pandemic, a dietitian-led nutrition training programme was developed for nursing and healthcare staff in a large NHS University Teaching Hospital in the Northwest. Focusing on dietetic referrals and knowledge surrounding basic nutrition care on the wards, the programme was set up in collaboration with the NNEdPro Nutrition in Education Policy and Healthcare Practice (NEPHELP) initiative and examined knowledge, attitudes and practices (KAP) related to basic malnutrition screening ('Malnutrition Universal Screening Tool' ['MUST']) and first line nutrition support in nursing and healthcare assistant staff.

Our model

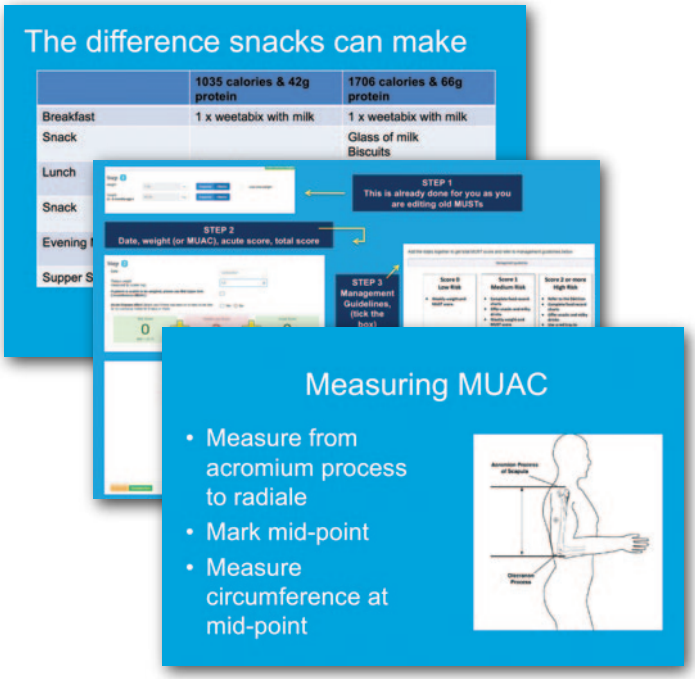
This programme was delivered as a pilot on a single hospital ward during two dedicated 6-week nurse training blocks from May-June and November December 2020. Sessions were delivered in six, 1-hour sessions by a single Band 5 dietitian and Band 3 dietetic assistant. Nurse's feedback on their experience of self-perceived KAP were gathered to explore the facilitators and barriers to implementing nutrition care and nutrition screening on the wards (**Figure 1**).

Figure 1: KAP Questionnaire pre/post 'MUST' training

Data was collected in pre/post training questionnaires as well as verbal feedback from participants during the training sessions. Perceived knowledge was examined through questions relating to confidence in completing malnutrition screening, and utilising nutrition/hydration knowledge with patients. A Likert-type scale was used to score KAP from 1 (not at all confident) to 5 (completely confident). Further to this, facilitators and barriers to using nutrition knowledge in practice were explored in the questionnaire and through open discussions. Similarly, key learning points from the sessions were recorded by participants. Lastly, referrals to the dietetic department were audited against referral criteria and correct completion of 'MUST' screening pre/post intervention to obtain objective insights into improvements in KAP.

Session content was planned by the dietitian and dietetic assistant, with tailored education to ensure compliance with local nutrition screening and assessment tools (including the 'MUST' tool, food charts and fluid charts). Session content also included interactive elements around food first approaches, the important of snacking, nutritional supplements, special menus and enteral feeds and feeding regimes. Some practical sessions on basic anthropometric measures were also included (**Figure 2**).

Figure 2: Presentation slides (tailored 'MUST', snack calculation, MUAC/Ulna)



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Findings

In total, 58 nursing and healthcare assistant staff were trained across the 12-week period, with level of qualification ranging from Bands 2-7.

Significant improvements were identified post-training in self-perceived knowledge of nutrition screening as well as in nutrition support practices from pre-post training sessions (median score 4 vs. 5 for both).

The most frequent barriers cited to implementing a greater focus on nutrition care in these roles were: 1) time pressures; 2) knowledge of nutrition guidelines; and 3) translation of guidelines into advice. These themes were further developed during the open discussion and free text responses in the questionnaires:

Time pressures

Nursing and healthcare staff cited time pressures as a major barrier to completing nutrition screening, as well as implementing nutrition knowledge in practice. Staff shortages and difficulty weighing and supporting patients at mealtimes were cited regularly:

"Having time to find working scales and weigh patients."
"More time to spend with patients at mealtimes."

Need for more training

There was a clear feeling among staff that their nutrition training could be improved.

"Need to update training so I can provide for staff."
"Not enough knowledge."

The need for regular updates and refresher sessions was also highlighted, as well as greater interaction with and support from nutrition professionals.

"More communications between nurses and nutrition teams."
"Regular training and refreshers."

Translation of guidelines into advice

In terms of translating knowledge into practice and complying with nutrition guidelines and standards, the need for more experience with patients was widely cited.

"Lack of practice."
"Need more experience as well as training and support."

Interestingly, uncertainty around record keeping was also referenced in a number of cases.

"Compliance with record keeping, i.e food charts."
"Knowledge of 'MUST'."

Post-training learnings were also recorded through questionnaires and discussions to explore key takeaways from the session and enablers to further develop knowledge. Again, similar themes arose across sessions.

Recognising and screening for malnutrition

Participants felt that their knowledge of completing 'MUST' assessments was improved by the session, as well as their ability to recognise red flags for patients at risk of malnutrition.

"Importance of recognising malnutrition, how to screen, how to treat."
"More knowledgable about MUST and referrals."

Some also reflected on gaining a broader understanding of the meaning of and criteria for malnutrition.

"How important malnutrition is at every size."
"Importance of recording height and weight (BMI)."

Improved knowledge and understanding

It was encouraging to hear staff recall specific pieces of knowledge taken from the training, which covered a broad range of topics related to implementing nutrition support in practice.

"Offering snacks between meals to boost calorie intakes."
"I know how to encourage eating to avoid weight loss."
"Diet is unique to each patient."

Referrals audit

Dietetic referrals from the ward who received training were audited in the weeks before and after each training block. These referrals were audited against departmental referral criteria as well as 'MUST' completion guidelines. In the weeks preceding training, the rate of appropriate referrals as per departmental criteria was 50% (6/12 referrals) and the rate of correctly completed 'MUST' screening was 25% (3/12 referrals). In the post training referrals audit, rate of appropriate referrals was 92% (12/13 referrals), with correctly completed 'MUST' at 77% (10/13 referrals).

Where next?

This short education programme was successful in improving the perceived nutrition knowledge of nursing and healthcare staff, identifying perceived enablers and barriers to implementing nutrition care in their practice and improving the quality of departmental referrals. The programme discovered useful insights into staff experiences of nutrition screening and care in their daily practice, as well as their relationships with nutrition professionals - which many identified as lacking or insufficient.

More widely, the importance of doctor's and nurse's knowledge of nutrition is understood to improve patient outcomes, but these professionals often lack education during clinical training, and are provided with limited training opportunities after the point of qualification to develop these skills further (Mitchell *et al.*, 2018; Macaninch *et al.*, 2020). Clearly, there is an opportunity to enhance nutrition education and training for all medical and wider healthcare professionals (Lepre *et al.*, 2022).

This intervention could provide a template for similar programmes to be undertaken which help understand local barriers to non-nutrition professionals implementing nutrition care in their practice. This programme helped to identify the priorities of those working within the service itself, allowing them to set the direction when developing further training based on local need. Furthermore, it can serve as a means of improving relationships between these practitioners and dietitians, through open communication, problem solving and shared learning. Moreover, given that the programme was developed and implemented by a single band 5 dietitian and dietetic assistant, it provides a low-resource activity with potential high value returns, as well an opportunity to provide additional responsibilities for and develop the skills of more junior staff.

References: • Lepre B, *et al.* (2022). Global architecture for the nutrition training of health professionals: a scoping review and blueprint for next steps BMJ Nutr Prev Health.; e000354. doi: 10.1136/bmjnph-2021-000354. • Nutrition Education Policy in Healthcare Practice (NEPHELP). Retrieved from: Macaninch E, *et al.* (2020). Time for nutrition in medical education. BMJ Nutr Prev Health.; 3: 40-48. • Mitchell H, *et al.* (2018). Models of nutrition-focused continuing education programs for nurses: a systematic review of the evidence. Aust J Prim Health.; 24: 101-108.