

P326

P326 -An examination of the dietitian workload on the renal ward.

Miss Joanna Finney¹

¹East And North Hertfordshire NHS Trust, Stevenage, United Kingdom

INTRODUCTION:

The role of the renal ward dietitian is diverse and requires expert knowledge of renal disease, and the management of diet and nutrition. It was hypothesized that the renal dietitian was spending substantial time carrying out nutrition related tasks that do not require dietetic qualifications or increased level of expertise. For example; assessing patients with a long hospital length of stay (LOS) for nutrition support and reviewing food and supplement preferences of non-complex patients. In some NHS trusts, these tasks are undertaken by a Dietetic Support Worker (DSW) or Dietetic Assistant Practitioner (DAP).

The objective of this study was to establish the range of reasons for dietetic consultation on the renal ward, and if the ward dietitian was meeting pre-determined key performance indicators (KPI's). These quality initiative KPI's were introduced following in-house audits which highlighted increased risk of malnutrition in nephrology patients with an increased hospital LOS and in acute patients commencing renal replacement therapy whilst on the ward. This information could then ascertain if there was a need for a DSW or DAP that would complement the specific and unique skills of a renal dietitian allowing for extended scope of practice and improvement of service.

METHOD:

A retrospective analysis of electronic patient records was conducted on 100 patients admitted to the renal ward over a 1 month period. The nutritional diagnosis of patients seen by the dietitian was audited to establish the breakdown of reasons for dietetic intervention. The pre-established departmental KPI's were also investigated.

RESULTS:

Of the initial patient cohort, 52% of these patients had dietetic contact. 58% of these were seen primarily for a nutritional support related diagnoses which included enteral and parenteral nutrition; oral nutritional supplementation and food first advice. The remaining 42% were seen for 'other' nutrition diagnoses including electrolyte imbalance; fluid balance; new start dialysis patient; increased length of stay and diabetes management. See Table 1.

In regards to the KPI's, 94% of patients classified as AKI or CKD unplanned start patients were seen within 3 days of commencing RRT. 79% of patients with an increased LOS classified as greater than 12 days were seen within 3 working days.

DISCUSSION:

Surprisingly, the number of patients seen for nutrition support related issues, although considerable, were lower than anticipated. This highlights the growing need for education and advice regarding electrolyte, fluid and diabetes management be provided on a ward setting, as opposed to in a clinic.

The data emphasised some areas of contact which did not require dietetic specific expertise. Patients seen for LOS included almost half the cohort. A number of these were seen exclusively for LOS, with no established nutrition diagnosis or need for dietetic intervention. Furthermore, LOS patients seen for food fortification and prescription of extra snacks, to meet energy and protein requirements was substantial.

Many nutrition support patient consults required multiple visits for review of snack, food and supplement preferences of which need not be carried out by a specialist dietitian.

What wasn't captured in this data was the number of dietetic contacts involved in these areas highlighted, and the amount of time spent reviewing these patients. Further analysis of this is underway, to support whether the addition of a DSW or DAP would prove valuable in this particular work setting.