RGP of Toronto Network Webinar

The Need to Improve Nutrition Care in Hospital: Early Learnings from More-2-Eat

May 19 2016

Dr. Heather Keller RD PhD FDC
Schlegel Research Chair, Nutrition and Aging
Schlegel – University of Waterloo Research Institute for Aging
Department of Kinesiology, University of Waterloo

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Accelerating Change Together In Ontario

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

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Outline

- Why do we need More-2-Eat?
- What is More-2-Eat?
- Key baseline data
- Implementation process
- Early Learnings on implementation
- Next Steps
  - Development of INPAC virtual toolkit

The Problem

(Allard et al., 2015; Keller et al., 2014)

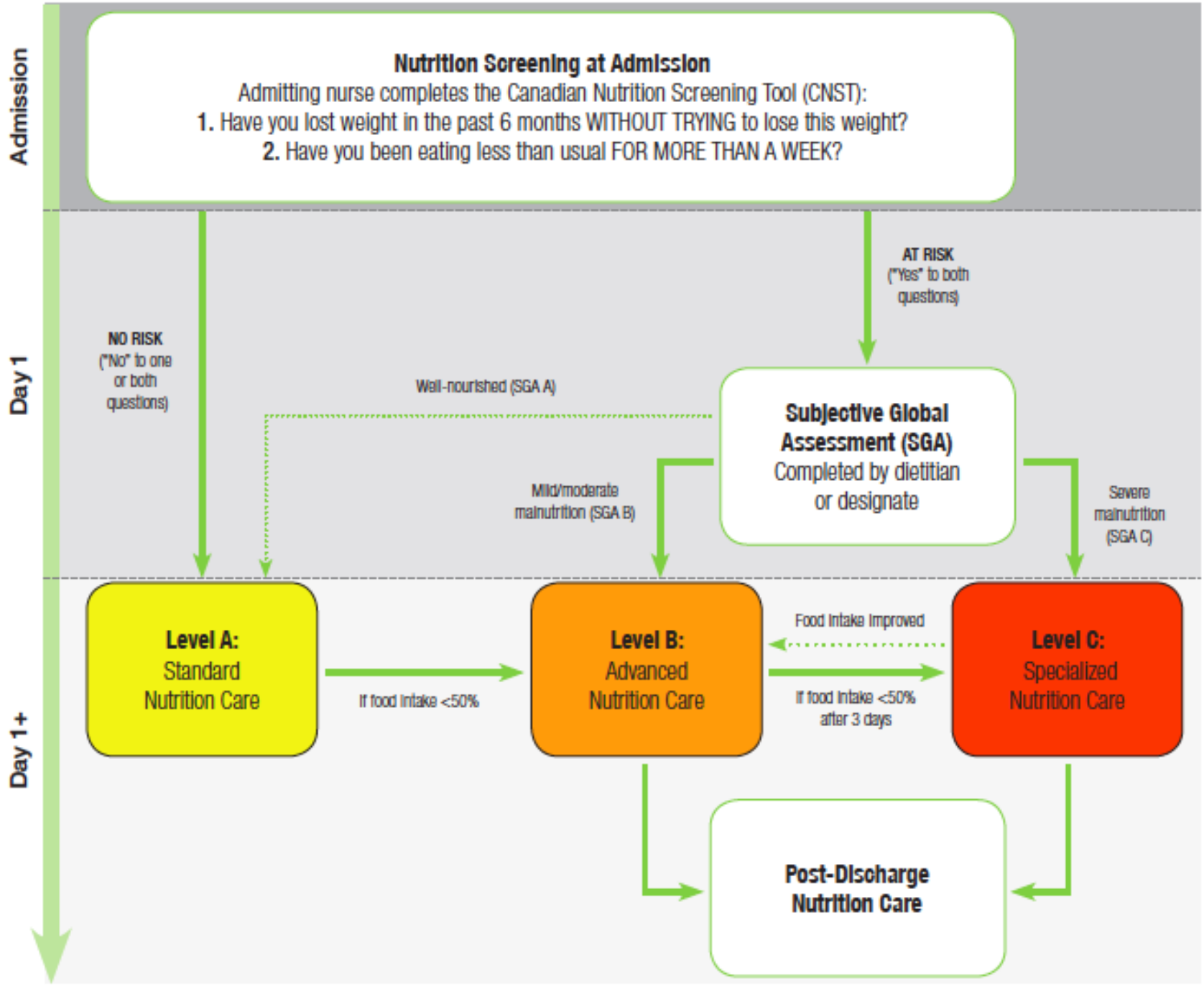
- **Prevalence of malnutrition in Canadian hospitals is 45% , majority are older adults**
- Nutritional status deteriorates in hospital for 20%
- Food intake < 50% and malnutrition are independent predictors of length of stay
- Malnutrition is costly in human and financial terms
  - $2000 + above well nourished per stay
- Treatment improves outcomes, but detection of those who need treatment is haphazard, missing most malnourished patients, especially frail elderly

The Response: The Integrated Nutrition Pathway for Acute Care (INPAC)

(Keller et al., 2015)

An evidence-based algorithm for the detection, treatment and monitoring of malnutrition amongst acute care medical and surgical patients.

- Developed through consensus from leading Canadian experts, clinicians and other stakeholders.
- This algorithm is a **minimum standard** and if a hospital or unit provides care above this minimum, they are encouraged to continue their high quality practice.


Admission
Day 1
Day 1+
Nutrition Screening at Admission
Admitting nurse completes the Canadian Nutrition Screening Tool (CNST):
1. Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight?
2. Have you been eating less than usual FOR MORE THAN A WEEK?
NO RISK
("No" to one or both questions)
AT RISK
("Yes" to both questions)
Well-nourished (SGA A)
Subjective Global Assessment (SGA)
Completed by dietitian or designate
Mild/moderate malnutrition (SGA B)
Severe malnutrition (SGA C)
Level A:
Standard Nutrition Care
If food intake <50%
Level B:
Advanced Nutrition Care
Food intake improved
If food intake <50% after 3 days
Level C:
Specialized Nutrition Care
Post-Discharge Nutrition Care

INPAC Best Practices

- Screen all patients at admission with CNST (day 1)
- Triage at risk patients using SGA (day 1/2)
- All patients receive Standard Care to promote food intake (e.g. opening trays, food access issues)
- Provide Advanced Nutrition Care strategies to mild/moderate malnourished
- Dietitian provides Specialized Care where required
- Monitor how patients are doing using their food intake
- Discharge planning for all mild/moderate and severely malnourished to promote successful transitions home

Canadian Nutrition Screening Tool

(Laporte et al., 2014)

Ask the patient the following questions	Yes	No
Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight? * * If the patient reports a weight loss but gained it back, consider it as a NO weight loss. .		
Have you been eating less than usual FOR MORE THAN A WEEK?		
Two "YES" answers indicates nutrition risk		

Taking Action: The 'More-2-Eat' Project

Objectives:

1) Test and evaluate implementation of INPAC in 5 diverse hospitals in four provinces
   - Feasibility, what influences implementation e.g. context
   - Improve nutrition care, PROM/PREM, staff KAP, resource utilization

   → Implementation toolkit

2) To test the feasibility of high protein (+500 kcal, 25g pro) supplementation for 90 days in frail malnourished; measurement of functional outcomes, body composition

Funding: Canadian Frailty Network (2015-17)

The M2E Team

- Multidisciplinary National & international
  - researchers/experts; co-investigators, collaborators, stakeholders
- Several HQP trainees at UW
- M2E champions, research associates, site implementation teams (SIT)
- Key Stakeholders: Canadian Malnutrition Task Force*, Canadian Nutrition Society, Dietitians of Canada*, Canadian Society of Nutrition Managers*, NNEdPro*, RGP Toronto/Senior Friendly Hospital*
- Collaborators: Abbott Laboratories*#, Nestlé# Health Sciences

*in-kind contributions, # financial

More-2-Eat Project Overview

Before-after time series design

Team Pre-Work

M2E Champion, M2E RA, Site Implementation Teams, management sponsorship

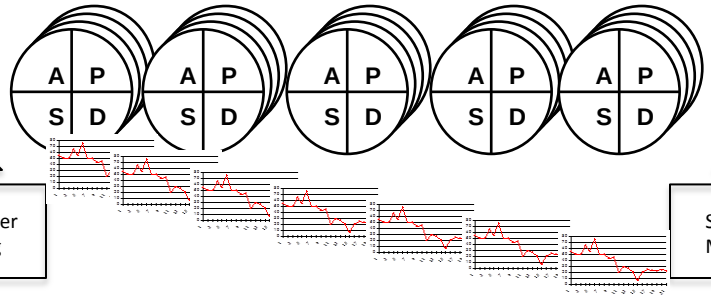
Planning

Collate Materials
Create Package, Measures and Educational Material

Introductory Webinars Among Sites

Baseline data collection
Patient risk, reported outcomes, INPAC activities, staff survey . Interviews, focus groups

Expert Panel etc.



Stakeholder meeting

Stakeholder Meeting

Sustained Change
Monitoring of Changes + Focus Groups

Distribute Findings
Program prepared to be rolled out in other hospitals
Publications

Communication/Support
Site Implementation Team Meetings; Teleconference among Site Teams and Core Research Group (monthly); Coaching (as required); Training for Staff

***Research Requirements**:*
Ethics Approvals; Baseline Data Collection; Context data collection

Site Data Collection and Analysis
Audit Reports (weekly; individual level); Score Cards (key actions/targets; facilitators, challenges); Indicator Reports (monthly; summary of audit reports);

Primary Analysis:
1. Comparison of baseline data to implmentation phase patient reported outcomes
2. INPAC Fidelity over time
3. Context assessment and impact on implementation
4. Resources required to implement INPAC
5. Feasibility of pilot intervention and measures

Enhanced Protein Supplement Pilot RCT (2 sites)
Patient recruitment; randomization, measures; follow up post discharge

Core Research Team Evaluation
Baseline, 4/5, 11/12 month selected follow-up post discharge for patient reported outcomes; context evaluation

Resource Utilization
Length of stay 12 mo prior and during implementation; selected patients receipt of mealtime care; monthly workload measures for selected staff

Developmental Phase: May to Dec 2015

Testing & Implementation Phase Dec 2015 to Dec 2016

Sustainability Phase Jan to Mar 2017

Measurement of INPAC

Patient Level

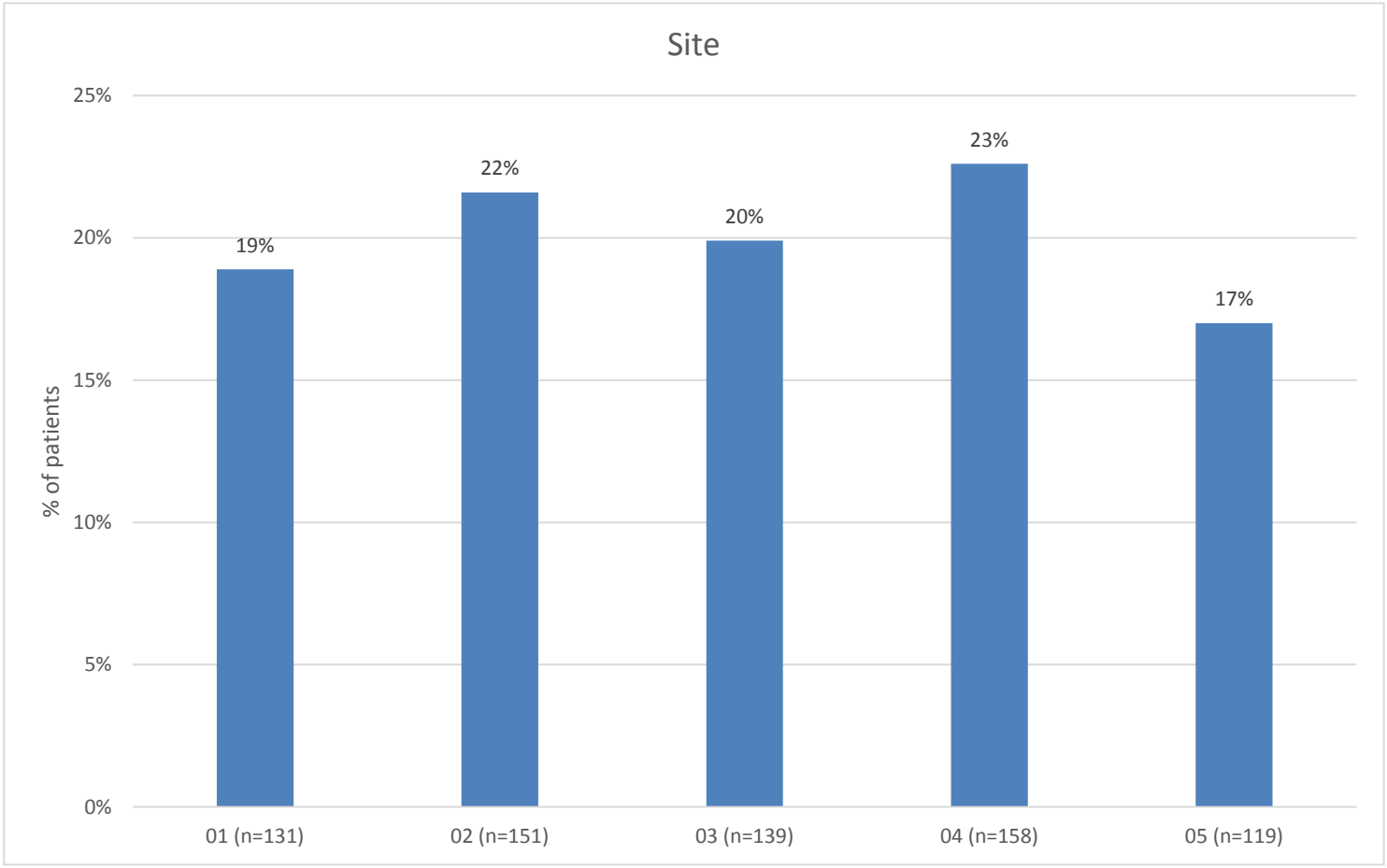
- INPAC audit
  - Nutrition care process
- In-patient subset
  - Demographics, condition, LOS
  - CNST, SGA
  - 5 m walk, HGS
  - Nagi disability, SF-12
  - M-MIT, MAT
  - Track mealtime resources
- 30-d outpatient subset
  - Resource use
  - Wt change, appetite
  - Nutrition resource use/gaps
  - SF-12, Nagi disability

Staff/Unit/Site Level

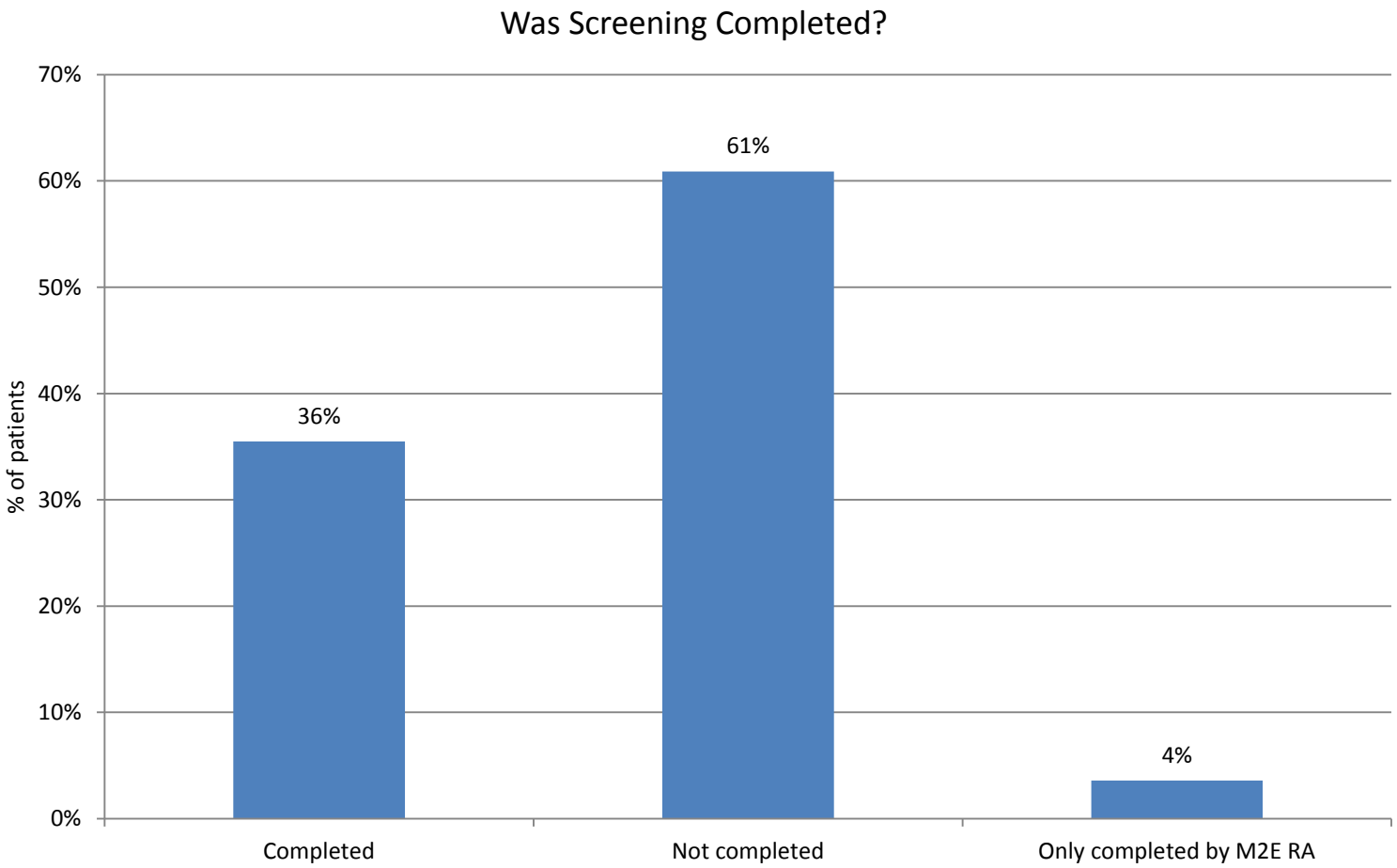
- RD workload
- Time for mealtime activities
- KAP survey
- Focus group/interviews
- Site survey
- LOS for unit pre/post
- SIT activities (Scorecard)
- Monthly coaching calls

Preliminary Results

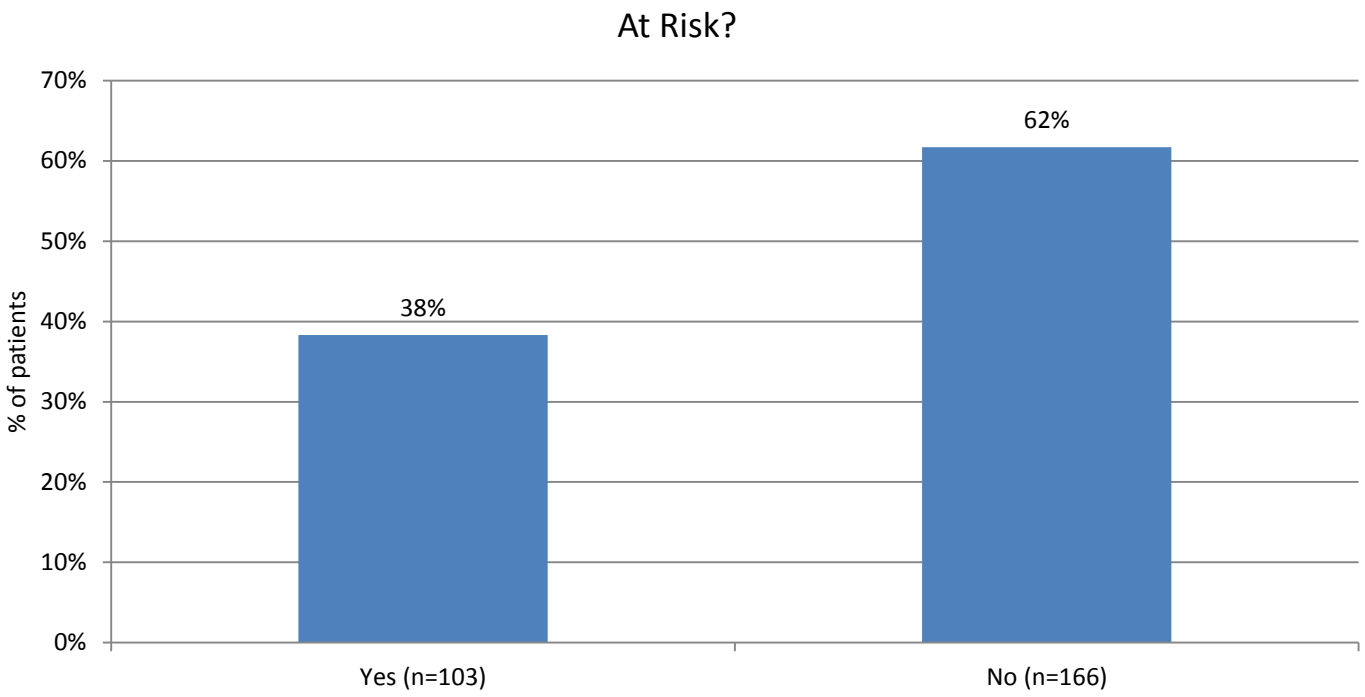
N=698 Audits, % per site



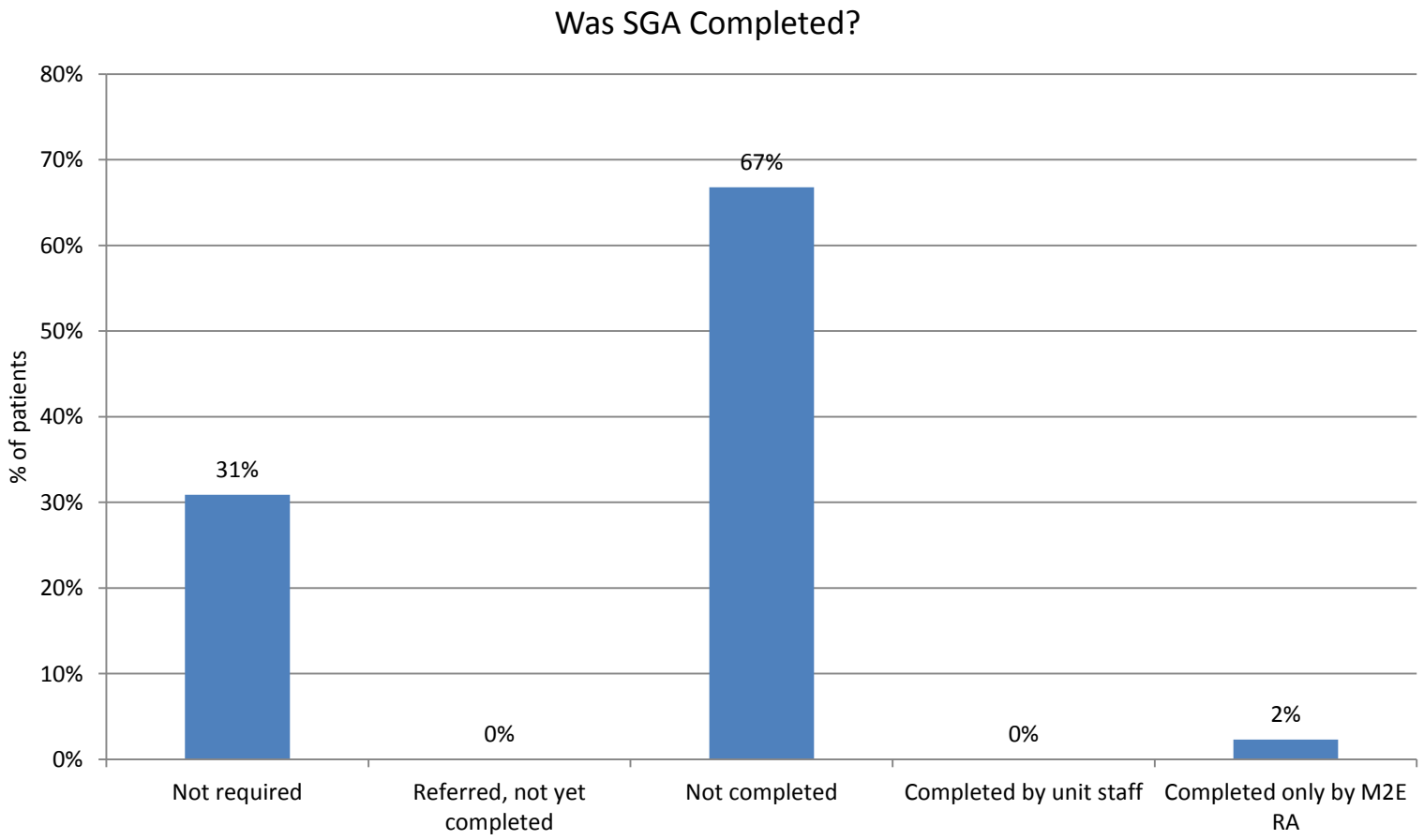
Screening


Was Screening Completed?
70%
60%
50%
40%
30%
20%
10%
0%
% of patients
36%
61%
4%
Completed
Not completed
Only completed by M2E RA

Of those screened (n=269)



SGA ?


Was SGA Completed?
% of patients
80%
70%
60%
50%
40%
30%
20%
10%
0%
31%
0%
67%
0%
2%
Not required
Referred, not yet completed
Not completed
Completed by unit staff
Completed only by M2E RA

Monitoring Food Intake

- Example: Whiteboards on each bed
  - ✓Strategy to have food service note % of food consumed on a whiteboard when they are picking up the meal tray
  - ✓**Facilitator:** Added nutrition into a current monitoring tool
  - ✓**Barrier:** Infection control re hand wash
    - **Solution:** Each food service worker has their own marker and they are not touching the board with their hands

Standard Care – Use of Volunteers

- *Example*: A volunteer training program was set up so volunteers could help during mealtimes
  - ✓ **Facilitators:** Education session; excellent support from volunteer coordinator; willing volunteers; interviews (by student) re staff opinions on use of volunteers during mealtimes (no objections)
  - ✓ **Barriers:** volunteer recruitment; volunteers cannot help with eating assistance;
  - ✓ M2E material: new slide deck re how a volunteer can help during mealtimes
  - ✓ Progress ongoing (program launched in April)

Hospital Discharge

- No sites are focusing on increasing nutrition in the discharge process

Facilitators

- Supportive team with good communication
  - Regular meetings results in goals being set and more readily acheived
- Take advantage of existing opportunities (changes to forms, availability of interns etc.)
- Increasing awareness about malnutrition across the site (newsletters, blogs etc.)
- Using monthly data to stimulate change

Barriers

- Uptake is slower in some sites
  - Education is not enough!
- Competing priorities in the hospital
- Low attendance at SIT meetings
  - Difficult to keep the momentum going
- Change management tools, including PDSA cycles, not being used consistently
  - Potentially over-formalize the change process?

Discussion

Acknowledgements

Canadian Malnutrition Task Force™ | le Groupe de travail canadien sur la malnutrition℠

Advancing Nutrition Care in Canada /Améliorer les soins nutritionnels au Canada

Canadian Nutrition Society
Société canadienne de nutrition

Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

In-Kind/Financial Collaborators

CMTF
Canadian Nutrition Society
RGP Toronto/Senior Friendly Hospital
Dietitians of Canada
Canadian Society of Nutrition Managers
NNEdPro
Abbott Laboratories
Nestlé Health Sciences

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Thank you for attending this webinar!

A link to a recording of this session and presentation slides will be emailed to you

You will also receive an electronic link to complete a quick evaluation of the session – please let us know how to improve these sessions and submit your suggestions for future topics you are interested in learning more about

Please join us for our next webinar **Thursday July 7 2016, 12-1pm**

Identifying Frail and Vulnerable Seniors in Primary Care

Dr. Ross Upshur

Professor and Head of the Division of Clinical Public Health,
Dalla Lana School of Public Health

Scientific Director, Bridgepoint Collaboratory for Research and Innovation

If you have additional questions, contact *ken.wong@sunnybrook.ca*