"Malnutrition Matters"
Implementation of Rehabilitation Assistants (RA’s) and Improved Nutritional Screening.

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Background
Early detection of malnutrition through nutritional screening of vulnerable risk groups can identify those who would benefit from specialised dietary support and intervention1.

Malnutrition is associated with negative outcomes for patients, including higher infection and complication rates, increased muscle loss, impaired wound healing, longer length of hospital stay and increased morbidity and mortality2.

Results indicate 32% of patients aged over 65yrs were at risk of malnutrition on admission to hospital, whilst 50% of those admitted from a care home setting were significantly at risk3. Despite this the National Institute for Health and Care Excellence (NICE) estimated that only 30% of patients were screened on admission to hospital1. This is due to a multitude of reasons e.g. Lack of education and training for staff, usability of screening tools and increased dependency of patients requiring far more interventions, amongst others4.

Nutrition risk screening is a simple technique to rapidly and accurately identify patients at risk of malnutrition and provides a basis for prompt dietetic referrals and intervention2.

Aims
To identify the impact of RA’s on compliance with nutritional screening and weighing at our Stroke Centre (SC), Llandough Hospital.

Method
In January 2016 six RA’s were employed at the SC for three months as part of the Integrated Stroke Workforce Plan, assisted by the CSIT. Using our local, validated nutritional screening tool:- Weight, Appetite, Ability to eat, Stress factor, Pressure ulcer/wound (WAASP tool) RA’s were trained to screen patients. This training formed part of the Agored Cymru – Nutrition Skills for Life accreditation.

The RA’s were tasked to perform weekly nutritional screening of a 15 bed section. Data was recorded in the Core Patient Risk Assessment Booklet, and on an RA dietetic checklist. Patients deemed to be at moderate nutritional risk were monitored as per the moderate risk care plan. Whilst patients deemed to be at high nutritional risk were referred to the Dietitian for nutritional assessment.

All results regarding RA screening were recorded for a period of 5 weeks and compared against standard care (routine screening by nursing staff).

Nutritional Screening Tool (WAASP)

Results
Percentage (%) Levels of Nutritional Screening & Weighing: RA’s v Standard Care: -

<table>
<thead>
<tr>
<th>W/C</th>
<th>% Weighed (With RA’s)</th>
<th>% Screened (With RA’s)</th>
<th>% Weighed (Std Care)</th>
<th>% Screened (Std Care)</th>
</tr>
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<tbody>
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<td>100%</td>
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<td>73%</td>
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Discussion
The implementation of RA’s had a positive effect on the rate of weekly weighing and nutritional screening of patients. However these results were not without their limitations. The gold standard for weekly weighing and nutritional screening is 100% compliance, but owing to staffing constraints RA’s were not always available to prioritise this intervention.

Conclusion
Utilising RA’s enabled improved compliance regarding weighing and nutritional screening of patients in comparison to standard care. Consequently, the likelihood of early detection of nutritional risk was increased allowing for appropriate care planning and nutritional intervention, thus enhancing the continued rehabilitation of the patient.

References