Organizational aspects of starting and running an effective nutritional support service

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Abstract—Setting up and running a Clinical Nutritional Support Team can be challenging and is time consuming. Team members have to be motivated, committed and persistent. High quality working relationships are fundamentally important within the team, between teams and with other healthcare professionals. Good communication, careful planning, sensitive implementation and robust monitoring are the cornerstones of a successful service. Looking forward as well as back will help the team to maintain and improve its position in an ever-changing environment. While nutritional support is everyone’s business, an effective multiprofessional Clinical Nutritional Support Team is the best way to ensure that patients receive appropriate and timely treatment. It is also wise to remember that a successful Clinical Nutritional Support Team will be as committed to its own development as it is to the care of the patients referred to it. © 2001 Harcourt Publishers Ltd.

Key words: nutritional support, clinical nutrition team; organization of nutritional support services; multiprofessional collaboration; team working; multidisciplinary teams; multiprofessional teams

Learning objectives

- To identify a framework for starting a clinical nutritional support team.
- To recognize objectives which can help a team to become established.
- To understand some of the key issues which can prevent a team from realizing its potential.
- To identify areas for future developments.

Introduction

Appropriate nutritional intervention is a core component of the clinical management of many disease states. It has been shown to improve clinical outcomes and shorten length of stay (1–5) as well as conferring qualitative and financial benefits (6–12). The organization of nutritional services is, therefore, becoming an increasingly important aspect of health care which should be explicit.

Nutritional care has often been provided on an ad hoc and fragmented basis and it is paradoxical that the process of clinical care can mitigate against the nutritional well-being of patients. Lack of awareness of the importance of nutrition permeates the ‘patient journey’. Screening for risk of nutritional problems on admission to hospital is not always routine practice (13, 14) and nutritional care in general is often poorly managed. Until recently the Catering Manager has been responsible for menu design, purchasing/preparing and delivering food to the wards. Nursing and ancillary services have then had the responsibility of ensuring that patients receive an adequate diet. Successive organizational changes have eroded this approach. These include external contracting for catering services, developments in clinical practice, organizational changes and technological innovations in catering such as cook-chill/cook-freeze meal provision (15, 16). These changes have often led to vulnerable patients becoming more nutritionally compromised. Limited medical and nursing undergraduate education in nutrition (17–19) has led to a lack of awareness about the adverse impact of undernutrition. This has been a further factor in the increasing numbers of reports about malnourished patients in hospital (20–23). Furthermore, arrangements for discharge and subsequent follow-up do not, necessarily, include any reference to nutritional care. It is not difficult to see why poorly managed nutritional support can exacerbate rather than alleviate morbidity (18).

Several initiatives have been developed in response to the general problems of undernutrition among the hospital patient population. These include the development of Nutrition Steering Committees (or Advisory Groups) (24), the provision of ward based kitchen services (16), nutritional ‘fortification’ of meals (25) and the critical review and redesign of patient menus (26). However, these and other similar local examples of good practice need to be disseminated and implemented on a much wider basis to ensure that there is maximum patient benefit.
Nutrition Steering Committees (NSCs) can be useful in helping to raise the profile of nutrition within the organization. An NSC will consist of representatives from many different areas including clinicians, managers (catering and general) and senior nurses (Fig. 1). An NSC can be a source of both information and support for a new Clinical Nutritional Support Team (CNST) and it will complement the clinical remit of a CNST. Ideally, both groups should be established within any hospital organization.

Clinical Nutritional Support Teams (CNSTs) have been developed to improve the nutritional status of individual patients particularly those requiring total parenteral nutrition. These small, responsive clinical teams usually include a senior physician/surgeon/intensivist, a nurse, a dietitian and a pharmacist (24). There may also be representation from other services – either on a permanent or an ad hoc basis. The remit of the team will vary according to local circumstances, interest and resource allocation.

The concept of CNSTs is not new but, despite awareness that undernutrition in hospital is a reality (18, 20–23), there are still relatively few CNSTs in Europe (27–31, BAPEN 2000: Unpublished data). The literature contains much about what a team can and should achieve but little about the process of starting and running a service. This paper highlights some of the key issues and suggests how they can be managed.

Making the case

The health care agenda is complex and many services including nutritional support are competing for scarce resources. It is important to identify who has influence within the organization and to remember that they are not necessarily the final decision makers. Making the case for a new service (or for the development of an existing service) is not easy and colleagues outside the CNST may be able to identify new issues which should be considered before a formal submission is made (32). Success depends on a variety of considerations and these are shown in Table 1.

The benefits of nutritional support and a multi-professional approach are well documented. Any new nutrition team should be aware of the seminal literature together with any reports which also question the benefits of a CNST (33, 34). It will be helpful to underpin this by reviewing local practice (35–38) and comparing it with any published data (10, 39). This could include audits of clinical practice, e.g. catheter sepsis rates; comparisons of practice between hospitals together with outcomes, e.g. catheter sepsis rates with/without a nutrition nurse specialist; and reviews of financial arrangements, e.g. the cost implications of not having a nutrition nurse specialist. The need for an evidence base to support any development is fundamental as well as being a core principle of clinical governance.

Most organizations have an annual programme for future planning and budget-setting. There will be various opportunities during this time to discuss a proposal in principle with key stakeholders, to submit it in an agreed format and, finally, to present the case on a formal basis. Failure to recognize these windows of opportunity could jeopardize a submission unnecessary.

<table>
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<th>Table 1 Making a successful case</th>
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<td>• Sell the organization something which is demonstrably in its interest and which will contribute to its overall strategy</td>
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<td>• Have the right product in the right place at the right time</td>
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<td>• Ensure that potential users of the service have realistic expectations</td>
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<td>• Communicate the messages consistently and continually</td>
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<td>• Minimize any perceived threats that the proposed service may generate</td>
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Fig. 1 Nutritional steering committee and clinical support team membership and operational relationships. —— Nutritional Steering committe. —— Clinical Nutritional support team. —— Operational Working relationships.
rily. This will result in frustration, possible loss of interest and a missed chance of success.

The way in which committees work together within large organizations is usually complex and can be daunting. It is important to identify which committees and individuals might have an interest in the development of a clinical nutrition service (32, 39). These could include service groups, e.g. catering and finance, specialty committees, e.g. medical/surgical advisory committees and function-specific committees, e.g. drug prescribing, nursing practice, clinical governance. The need to gain the individual support of influential committee members as well as the decision makers is crucial and this should be achieved before any meetings take place thereby minimizing the potential for a proposal to be undermined.

**Role clarification**

Multiprofessional working must be perceived as an opportunity to integrate the unique expertise of each individual. This is vitally important and the team members need to be aware of each other’s particular knowledge, skills and attitudes to practice. However, many teams flounder because overlapping areas of practice are not also clarified which can lead to professional jealousy. Several tasks can be undertaken by more than one professional, for example some aspects of nutritional assessment and nutritional monitoring (32,41). This is particularly relevant when considering professional roles within different countries (27). Successful collaboration depends upon these areas being identified and proactively managed so that each member not only recognizes their contribution to the team effort but is also aware that this has been agreed by the team as a whole.

**Boundaries of clinical care**

The remit of clinical teams can overlap in the same way as the roles of individual team members. Clinical colleagues must be informed about any arrangements that a CNST may make because these may impact on their areas of practice. The presence of a senior doctor on the CNST is particularly helpful on such occasions because he/she is, probably, in the best position to influence other clinicians. Conversely, lack of senior medical involvement has been identified as a constraint to effectiveness (10, 39).

**Policies and procedures**

The appropriate introduction and use of policies and procedures has several benefits. These include safe practice, effective risk management and enhanced quality of care as well as legal protection (42–44). Any new processes must be widely discussed, carefully negotiated and collectively agreed. Clear documentation underpins successful management and new paperwork should always be widely piloted to ensure that potential difficulties are highlighted sooner rather than later.

Any service must be explicit and, among other activities, it will be important to set up a clinical audit programme for the CNST at an early stage. This should include a regular review/update of the paperwork and practices which will improve patient safety as well as providing useful organizational information (Note: if a policy or procedure is updated, a copy of the original(s) must be kept for medico-legal reasons).

**Communication**

This has to be consistent, reliable and unambiguous at all levels to help ensure safe practice. Successful nutritional support does not happen by accident and, usually, many people are involved so any meetings must be timely and well managed (45). Failure to communicate regularly and effectively can cause confusion and may compromise patients (46). It is mandatory to record
information about nutrition provision/management in the patients’ case notes and this must be established at the outset. It may also be necessary to liaise separately with other professional staff and the means for expediting this must be clarified. Awareness of colleagues’ routine schedules and priorities will help to maintain a sensitive approach to nutritional care. Finally, the team must be easily accessible thereby facilitating communication and liaison.

Patient focus

Patients’ expectations of healthcare have rarely been higher but, although apparently obvious, it is not always easy to develop a true patient focus of care. Much clinical practice, although claiming to be patient-centred, is traditionally didactic and prescriptive. Nutritional support demands an unusually high level of patient/carer cooperation if compliance and improved outcomes are to be achieved (46, 47). This may require some significant changes in attitude coupled with the acquisition of new competencies (48). Well-developed listening skills, an ability to negotiate and willingness to compromise are fundamental to success. Involving patients/carers whenever appropriate and possible in discussions and decisions about their treatment, particularly if long term intervention is likely, will help to achieve better outcomes (49–51). These, in turn, will generate a positive perception of CNST activity.

Education and training

Clinical colleagues need to know how the CNST functions and how it will help them. Initial publicity will raise a range of expectations and these should be individually addressed. One approach is to ensure that any new documentation and/or working procedures are well publicised. This is particularly important if there is potential overlap with other individuals or teams. Concise, well-structured education and/or training programmes are invaluable in this respect although they may need to be delivered at ward level to ensure maximum attendance.

Keeping going

Many nutritional support teams function very effectively at the outset but fail to maintain this momentum. These failures usually arise from shortcomings within the team or from organizational changes and other external constraints (52–55, BAPEN 2000: Unpublished data). Whatever the problem (and whether it is perceived or reported) it is imperative that it is resolved quickly and effectively so that CNST credibility can be maintained.

Generating and maintaining enthusiasm is an active process and, if this is ignored, a CNST will not flourish (55). This may mean identifying time on regular basis to review team activity/progress and to discuss any difficulties. Some possible topics are listed in Table 2.

Team welfare and motivation

If a team does not nurture itself, it is unlikely to develop and eventual failure becomes inevitable. Successful teams have a high level of mutual respect and trust and these qualities must be diligently fostered. The need to identify protected time for team meetings is crucial and should always be a priority. Team members can interact at three different levels: related to the patients, interprofessionally and personally. Different strategies will be needed in each situation. The patient focus is best maintained by regular contact on a multiprofessional basis. Keeping abreast of the literature provides a framework for interprofessional debate and development but other options may also be considered. Attending professional meetings will provide a forum for team discussion as well as encouraging the development of new ideas and skills. The benefits of ‘networking’ are also invaluable and these can be optimized at such meetings. Working relationships often tend to be more focused and effective when team members share a degree of personal insight. However, this is sometimes difficult to develop in a busy working environment and team-based social events can be a useful way to achieve this!

Team working

A team can be viewed as a group of people who make different contributions to a common goal (56). CNSTs can be based on one of the following models:

1. a multidisciplinary (multiprofessional) team when individuals work to achieve individually set goals and then meet to discuss progress;
2. an interdisciplinary (interprofessional) team when there are shared goals with coordinated input into a common treatment plan;

Keeping the team going

'We trained hard but it seemed that everytime we were beginning to form up into teams we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganizing, and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralization.]

Caius Petronius (A.D. 66)

Table 2 Key characteristics of a successful team

| • Attention to team welfare and motivation |
| • Effective team working |
| • Shared team vision |
| • Robust clinical audit programmes |
| • Focused research |
| • Strategies for sharing success |
A transdisciplinary (transprofessional) team when there are shared goals and skills.

Most CNSTs can be identified within the first two categories – progressing from a multiprofessional to an interprofessional basis as competence and confidence develop.

When people work together in a team distinct individual characteristics can be identified (57). A balance of these, e.g. leadership, information gathering, networking, finishing tasks and lateral thinking will ensure the ‘ideal team’ – particularly if team members can use their skills to best advantage. Other important aspects of team working center around clarification of arrangements for decision-making, handling conflict and liaison between team members (56, 58).

**Team vision**

A strategic plan is an important determinant of success and, if properly developed, will demonstrate what achievements have been made and what still needs to be done. It can also be used to review priorities on a regular, planned basis. Input from colleagues outside the team can be very helpful because key stakeholders in the service may have a slightly different agenda, in which case it may be politically expedient to reprioritize objectives. This is an excellent reason for keeping colleagues up-to-date about activity and progress. One important aim of the team should be to add an explicit quality element to routine service provision thereby meeting the mandatory requirements of clinical governance.

**Clinical audit**

This is a major component of clinical governance of which the primary objective is continuous improvement. Clinical practice is dynamic and evolutionary and this will be reflected in the work of a CNST. An agreed audit and peer review programme is important for identifying progress and for highlighting any difficulties which might be preventing this. Critical and continuing audit of the service will also reveal any shortfalls and can be used to introduce improved practices which will enhance service provision (59–64). Audit is also a means of establishing success and reviewing any clinical/financial benefits resulting from CNST activity. In short, it is an opportunity for the CNST to be seen to be practising safely and responsibly and every effort must be made to allow adequate time for audit projects.

**Research**

A CNST is ideally positioned to initiate research into many areas of nutritional intervention and management. There is the potential to link with other centres to undertake more meaningful trials as well as developing new initiatives. Most organizations are committed to supporting research and any new activity will be welcomed – this is another way in which the profile of a nutritional service can be raised. Research is also, potentially, a means of attracting income.

**Sharing success**

Nothing succeeds like success – and success should be shared! Raising the profile of the team will have many benefits which will include improved team morale. Colleagues who have helped and supported the team will be happy to share in the successes to which they are very likely to have contributed. Conversely, failure to publicize successes can lead to senior managers and clinicians (the ‘influencers’ and ‘decision makers’) overlooking any positive contributions that a CNST may be making towards achieving organisational objectives.

Success can be publicised in several ways including grand round presentations of difficult cases, clinical audit reports, annual progress reports and contributions to journal clubs. Electronic information sharing should be encouraged, e.g. using an intranet service, if available, or contributing to the organization’s website. Finally, the impact of producing articles for in-house publications as well as for professional journals should never be underestimated.

**Managing organizational change**

There are several ways in which the success of a CNST can be undermined. Some of these cannot be predicted but all of them should be managed. These are summarized in Table 3.

**Staff changes and shortages**

These are usually due to leave and/or underfunding (BAPEN: Unpublished data). However, they can be critical in a small team with specific clinical expertise which may make recruitment particularly difficult (65). This is a powerful argument to support a team in identifying core skills and information which can be

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<td>Staff shortages</td>
<td>Train other healthcare professionals</td>
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<td>Changes in service provision</td>
<td>Be aware of potential developments</td>
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<td>Maintain regular contact with Nutritional</td>
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<td>Steering Committee/appropriate managers</td>
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<td>Respond to change positively</td>
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transferred to other healthcare professionals. Such training could enable a minimal service to be provided during a crisis as well as enabling some extended service provision, for instance, out of hours or at weekends. Changes in team membership can also compromise service provision (55, 58) and these need to be carefully managed with an effective induction programme together with explicit support from the other team members.

Changes in service provision

These, too, are a constant feature of current healthcare (53). They can be caused by changing national priorities or by local alterations in casemix and/or clinical practice. The impact of such changes can be minimized by being aware of potential developments and by responding to change positively while continuing to deliver a patient-centred, quality-driven service (53, 59–63). It is always useful to maintain regular contact with appropriate service managers such as those for Business Development, Operations and Specialist Services. A Nutrition Steering Committee can also be a useful source of information.

Communication breakdown

This is frequently cited for lack of effectiveness and arrangements within the organization are often blamed. Close and consistent liaison between a CNST and other clinical colleagues/teams is essential for successful nutritional intervention. This is particularly important when communicating information about patients and clearly written, timely casenote entries must be mandatory. It is the responsibility of the team to identify appropriate mechanisms to ensure that this happens and that the team continues to be easily accessible and responsive to requests for help.

Sometimes communication between team members can break down and this could be for a number of reasons. Commonest among these are conflicting clinical priorities, service pressures, perceptions of unfair treatment, professional jealousy or individual members developing interests in other areas of practice. Whatever the reason, an open team talk is needed and this should be arranged at the earliest opportunity.

Financial issues

Planned development is a feature of all large organizations and any funding challenges faced by a CNST should be addressed within this framework. Conflicting priorities are often a problem when resources are scarce and CNSTs are vulnerable in this respect. It is useful to be aware of the organizational ‘drivers’ and to make friends with the appropriate senior managers and accountants. Being affiliated to a larger, clinical service may also be helpful. A well-advertised schedule of activity can also reassure the ‘decision makers’ about the important contributions that a CNST can make to the achievement of organizational objectives.

Future developments

CNSTs must be proactive and responsive (53, 66, 67). There are many opportunities for development which will depend on local priorities and enthusiasm together with available resources.

‘Mainstream’ services

Nutritional support is not, currently, considered in this way despite studies showing that substantial numbers of patients are either undernourished on admission to hospital or become so during their stay in hospital (20–23). Although there are signs that national directives and initiatives may have an impact at local level in some countries, a longer term goal for any CNST must be to achieve recognition and integration as a primary clinical service. This will safeguard its function and funding when hospitals are faced with conflicting financial pressures. The importance of evidence based data is crucial (39, 66) and the development of integrated care pathways is another approach which could help to consolidate CNST activity (68). The potential for external assessment–‘accreditation’ using or augmenting existing programmes should also be considered (69–71).

Education

The interest in nutrition at national level is increasing and it is the responsibility of those working in the field to contribute to any developments. An important aspect of this is to support any educational initiatives. Several countries are involved in regular informal post-graduate programmes (27) and ESPEN has also developed courses with the aim of developing nutritional knowledge and skills. Regular evaluation shows that these are well received (ESPEN – unpublished data). It is important to develop a more formal approach to nutritional education on both a uni-professional (Accreditation of Specialist Registrars, Royal College of Physicians, England) and on a multiprofessional basis (including the ESPEN Advanced Course in Clinical Nutrition, Maastricht – Bonn and BAPEN Practical Nutritional Support – Working Together).

Centres of excellence

These are recognized by most clinical specialists but there are relatively few centers with recognized multiprofessional expertise in nutritional support. There is the potential to develop a variety of activities ranging from clinical demonstrations, clinical supervision and focused educational sessions to various mentoring
activities. The possibility of introducing a structured multiprofessional learning programme leading to a formal qualification should be considered; there are, already, some examples of such initiatives (72, 73). Such developments would not only enrich current practice but would also encourage others to join an exciting area of clinical activity.

Clinical advances

These are on-going and the provision of nutritional support at ward level should reflect continuing research and development. Improved technology will make catheter care and the delivery of nutrients simpler and safer. It is possible that enteral feeding will become more widely used not only as the sole means of support but alongside parenteral nutrition to optimize nutrient utilization (74). CNSTs must work flexibly and creatively to make the most of new opportunities.

Community based service delivery

There are data to show that significant numbers of patients are undernourished on discharge from hospital (75). Changes in clinical practice, technological development and altering patient demography have also contributed to a significant increase in home artificial nutrition (29–31, 76, BAPEN 2002: Unpublished data). The delivery arrangements for supporting patients at home are increasingly well-developed but the associated clinical support is often fragmented. CNSTs should respond to this by developing effective outpatient and/or outreach services and by helping to establish community based nutritional support teams.

Information technology

Developments in electronic communication have made information quickly and readily accessible. It is easy to liaise with colleagues from other centres and a range of options exist to simplify problem solving. Making the most of such opportunities also facilitates other activities notably research, clinical audit and education. These are all key factors in enabling a CNST to deliver a high quality service.

Conclusion

CNSTs can operate in different ways which will be governed by local circumstances. There are many potential hazards and pitfalls which must be anticipated and proactively managed if the team is to be successful. The key to this success lies in effective clinical service provision, high quality communication and providing explicit ‘added value’ to the organization.

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