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Nutrition Care Process Implementation: Experiences in Various Dietetics Environments in Sweden

Elin Lövestam, PhD, RD*; Anne-Marie Boström, PhD, RN; Ylva Orrevall, PhD, RD*

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*Certified in Sweden.

ABSTRACT

Background The Nutrition Care Process (NCP) and Nutrition Care Process Terminology (NCPT) are currently being implemented by nutrition and dietetics practitioners all over the world. Several advantages have been related to this implementation, such as consistency and clarity of dietetics-related health care records and the possibility to collect and research patient outcomes. However, little is known about dietitians' experiences of the implementation process.

Objective The aim of this qualitative study was to explore Swedish dietitians' experiences of the NCP implementation process in different dietetics environments.

Method Thirty-seven Swedish dietitians from 13 different dietetics workplaces participated in seven focus group discussions that were audiotaped and carefully transcribed. A thematic secondary analysis was performed, after which all the discussions were re-read, following the implementation narrative from each workplace. In the analysis, The Promoting Action on Research Implementation in Health Services implementation model was used as a framework.

Results Main categories identified in the thematic analysis were leadership and implementation strategy, the group and colleagues, the electronic health record, and evaluation. Three typical cases are described to illustrate the diversity of these aspects in dietetics settings: Case A represents a small hospital with an inclusive leadership style and discussion-friendly culture where dietitians had embraced the NCP/NCPT implementation. Case B represents a larger hospital with a more hierarchical structure where dietitians were more ambivalent toward NCP/NCPT implementation. Case C represents the only dietitian working at a small multiprofessional primary care center who received no dietetics-related support from management or colleagues. She had not started NCP/NCPT implementation.

Conclusions The diversity of dietetics settings and their different prerequisites should be considered in the development of NCP/NCPT implementation strategies. Tailored implementation strategies should be considered in relation to context, such as increased dietetics support and facilitation where management does not lead or support the implementation process.

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OVER THE PAST DECADE, NUTRITION AND DIETETICS practitioners all over the world have implemented the Nutrition Care Process (NCP) and its associated terminology (Nutrition Care Process Terminology [NCPT], formerly International Dietetic and Nutrition Terminology). The NCP was developed by the Academy of Nutrition and Dietetics as a framework for logical thinking and decision making in dietetics. It contains the following four main steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention and Nutrition Monitoring, and Evaluation.[1] The NCPT was developed to support dietetics communication, clinical documentation, and research, and provides standardized terms for each of the four NCP steps.[2] For the second step, Nutrition Diagnosis, this standardized diagnostic term is to be connected to a specified etiology and measurable signs and symptom, forming a problem-etiology-symptoms (PES) statement.

The NCP steps and their connections and mutual relationships provide a critical link between research and practice, facilitating the systematic collection and measurement of dietetics care outcomes.[3] These can be used both in research and in the monitoring and evaluation of dietetics care quality. Studies have shown advantages in using the NCP/NCPT, such as facilitating the provision of a consistent structure for nutrition care, promoting critical thinking and a decision process, enabling clearer and more consistent and informative dietetics-related notes, and the increased recognition and acknowledgement of the

dietitians' competence by other health care professionals.[4-6] However, studies also show that the high expectations that dietitians have of the NCP/NCPT implementation are in reality only met to a certain degree, and that some dietitians experience difficulties balancing the standardized process and terminology with a more flexible, patient-centered approach.[5,6]

In recent years, international interest regarding the implementation of NCP/NCPT has increased among nutrition and dietetics practitioners.[7-10] Today, the NCPT/NCPT is being implemented in several parts of the world, and various editions of the terminology have been translated into different languages.[11] The first translation into Swedish was published in 2011, when the Swedish NCP/NCPT implementation was started.[12] The NCP/NCPT is now included in the curriculum of all dietetics programs at Swedish universities, and is also increasingly used in clinical documentation and as a framework for the development of dietetics-related clinical guidelines in different care settings. NCP/NCPT use is also recommended by the Swedish Association of Clinical Dietitians (DRF).[10] Almost all Swedish dietitians write their clinical documentation in electronic health care records (EHRs) that contain preset key words or headlines, which in some care settings, but not all, are based on the NCP steps and NCPT. The Swedish implementation is not governed by the DRF, but is rather the responsibility of the managers of each individual setting where dietitians work.

In an Australian survey, open-ended questions showed that dietitians (n=16) considered that time resources, regular tutorials, and supportive management were key elements for successful NCP/NCPT implementation.[13] In the same study, dietitians in two focus groups found that peer groups, leadership teams, structured deadlines, and the submission of PES statements with subsequent support were valuable for the implementation. The main barrier identified was lack of time resources.[13] In other studies it has been argued that the use of EHRs facilitates the NCP/NCPT implementation when compared with the use of paper records.[14]

Implementation of the NCP is a comprehensive process that is currently ongoing in several countries around the world. So far, only a few surveys together with some minor implementation reports from different hospitals have addressed dietitians' perspectives regarding this fundamental conversion. Very little is known about dietitians' own experiences of the implementation process, such as which factors support or hinder the process. In the exploration of processes and contexts of phenomenon, qualitative approaches can contribute with new perspectives and provide valuable insights.[15] These can in turn be used to generate hypotheses for new studies. No study using a fully qualitative approach has so far explored dietitians' experiences of implementation. The aim of this study was to use a qualitative approach to explore Swedish dietitians' experiences of the NCP implementation process in different dietetics environments. In this article, the concept "dietetics settings" refers to different clinical settings where dietitians work. "Dietetics environment" refers to the environmental or contextual aspects of these settings. "Manager" or "management" will be used to refer to both managers of specific dietetics departments, but also to general managers of interprofessional departments or other settings where dietitians work.

METHODS

Focus Group Discussions

This study consists of a secondary analysis of focus group discussions addressing the Swedish NCP/NCPT implementation. The original aim with the focus group study was to explore dietitians' experiences with the use of NCP/NCPT in relation to patients, the documentation, and the professional role.[6] However, to a large extent, the focus group discussions included dietitians' experiences with the implementation process and the factors that the participants perceived as barriers and facilitators in this process. The researchers decided to include these perspectives in a secondary analysis of the material.

In 2015, an updated version of NCP, and an electronic updated version of NCPT were launched. Because the focus groups were performed in 2014, the discussions refer to the earlier version of the NCP/NCPT, which was released in 2008.

To capture a broad range of views, focus groups were chosen as the research method. Seven semistructured focus group discussions were held, where 37 dietitians from 13 different settings discussed their experiences of the implementation.[16] Three to eight dietitians participated in each focus group. Table 1 provides further details.

Inclusion criteria for the focus groups were dietitians with a minimum of 1 year's working experience and at least a basic knowledge of the NCP/NCPT. These criteria were met with the exception of a few dietitians: one with less working experience and a few with less NCP/NCPT knowledge. However, because these dietitians made valuable contributions to the discussions concerning, for example, their reasons for not implementing the NCP/NCPT, they were included.

One of the focus groups was held at a university close to the participants' workplace; the other six were held at various hospitals where many of the dietitians worked. The discussions all lasted for 60 to 90 minutes and were moderated by the first author (E.L.), who has extensive experience of leading group discussions. They were all audiotaped and carefully transcribed verbatim by the first author. An external observer was also present at all sessions, taking field notes to facilitate the transcription and interpretation of the discussions.[16,17] Before each focus group session, participants were asked to complete a short questionnaire asking for background information.

The selection of participants was purposive, including dietitians from several different parts of Sweden and of different ages, to include a variety of experiences concerning education, health care settings, EHR use, and NCP/NCPT implementation. The participants were recruited by e-mail messages sent to dietitians at the largest hospitals in different parts of Sweden and to members of the national dietetic association. The e-mail messages included information about the study and a request to participate in the focus groups. When dietitians from different parts of Sweden responded to the call, e-mail messages were sent directly to hospitals and primary care centers in these specific areas in Sweden to encourage more dietitians to join the planned focus groups. This second step of the recruitment process was done to ensure a sufficient number of participants, with a broad spectrum of experiences in each focus group.