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P327 -An audit on nutritional screening practice in patients with Chronic kidney disease

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The incidence of malnutrition in patients with Chronic kidney disease (CKD) admitted to the hospital is around 50%. Screening for malnutrition is the first step of the nutrition care process. Nutrition screening tools assess the risk of malnutrition and identify those patients requiring a full nutrition assessment. We conducted an audit to review the nutritional screening practices and assess the implementation of the nutrition screening tool (NST) on a renal ward, due to observed inconsistencies in practice
Aim: To investigate the rate and accuracy of completion of a locally used NST and assess the implementation pathway of the NST at ward level
Methods: A case-note review was undertaken to assess medical notes, nursing handover, nursing kardex, NST and food record charts for all inpatients on 2 renal wards over a month. The number of NST completed within 24h of admission were counted and the accuracy of completion was estimated by comparing the most recent NST scores with the scores assigned by the ward dietitian at the point of data collection. Subsequently, the recommendations from the NST were reviewed to establish whether the implementation pathway was adhered to and whether patients were being appropriately referred to the renal dietetic team. Additional observations made during data collection were also considered for a deeper understanding of the NST implementation.
Results:
The data was obtained for 47 inpatients (60% males). The NST was completed within 24h of admission for (n=33) 70% patients, and weekly thereafter in 60% patients. A score comparison revealed that out of 36 patients, only 28% (n=10) patients had NST scores, which matched the scores assigned by the dietitian. Based on the recommendations from NST, 45% patients had food charts in place, 52% were offered nutritional supplements and only 1 out of 4 patients requiring dietetic referral, were appropriately referred. Inconsistencies were also observed in NST implementation pathway, food charts and offering nutritional supplements, where required. Additionally, patients classified as high risk according to NST were not referred to the dietitian despite an increase in their weekly NST scores.
Conclusion:
This audit highlights inadequate nutritional screening on the renal wards. Additionally, the NST implementation pathway has not been adhered to, which denied the patients, access to renal dietetic expertise. It is vital to identify malnutrition in its early stages to provide timely intervention and reduce its prevalence.
This warrants the need to identify barriers to effective implementation of the nutritional screening pathway and highlights the importance of staff education towards nutrition in CKD with the aim of changing practice and improving patient outcomes, which will need confirmation by reaudit to complete the cycle.