Output O2: Unified framework of the Dietetic Care Process (DCP)

1. O2/A2: Evaluation of strengths and weakness of framework DCP

Aim

Investigation of the use of the framework DCP in the different countries and current problems in implementation of the framework DCP by using methods of data collection such as interviews (qualitative research). Understanding and conducting in-depth discussions about the differences between the DCPs and the problems with implementing DCP.

Methods

a) Collecting information about the use of DCP and current problems in the four different countries (Austria, Belgium, Germany, The Netherlands) by written short interviews/statements.

Every project partner wrote a short statement to answer the following two questions:

- How is the use of the framework in your country?
- Which current problems in implementation do exist?

b) Based on the results of the comprehensive descriptions of the four different DCPs (O2/A1) the strengths and weakness of the framework DCP was worked out.

Results

a) Table 1 shows the written statements of all project partners.

Table 1: Short statements about the investigation of use and current problems in implementation of the framework DCP from each project partner:

Austria	1. How is the use of the framework in your country? In Austria students at HEI´s need to write at least 10 dietetic care processes during the 6 terms (MTD-AV 2006). The forms used by students differ slightly between HEI´s in Austria. 2. Which current problems in implementation do exist? The process steps are written (no process model visualization) in the MTD-AV 2006, a visualization has been published in the ÖBIG report in 2003, where the process model we added to O2/A1 has been adapted from containing 8 steps. The used forms in Austrian HEI´s are similar, but not same. Different spelling: Diätologischer vs. Diaetologischer Prozess

	Dietitians often report that they work along the dietetic care process since these a logical steps, but do not report/document data as comprehensive as students do. Students (and I assume also dietitians) do have difficulties allocating information to each step. We do not have an agreed system on forming dietetic diagnosis, or how to document our work, eg. some hospitals only have two codes for dietitians: eg. one for therapy and one for consultation. Also, we have different process models in Austria, one was developed in 2003 by the ÖBIG (find references in literature Austria on Trello), and each HEI uses a slightly different process model, but all linear. The Austrian Association of Dietitians provides some information what belongs to what steps in the process model, but too less information to be helpful for e.g. students. There isn´t an official english version of our process model as well, the translation we have provided for the project is our own one. The two different model visualizations: Additional, we have the impression that dietitians see the dietetic care process more as tool for teaching rather than for practical application during dietetic therapy etc. There aren´t case studies published as well, so dietitians don´t see how the process could be applied in practice without immense production of material (which students often do, because they don´t know where to focus on yet). The Austrian dietetic process was defined by law not only for clinical dietitians, but also for Health Promotion and Prevention, Nutrition Marketing and Nutrition Communication. No existence of standardized language and documentation. Another weakness: Misunderstandings that always all process steps need to be done - sometimes and depending on the intervention, the step for planning and implementation can be quite short, if the patient/client/user is only seen for one consultation, evaluation of intervention is not possible. The logic of the process steps and content are discussed - some think that documentation is the final step in the process, wheras others see it as quality tool that needs to be done within each step.
Belgium	1. How is the use of the framework in your country? As you know we follow the “dietisch consult” from the Netherlands (Boom/Lemma). We don’t have documents with a description of the NCP/DCP for Belgium, but all HEI’s follow more or less the Dutch steps. Evenmore, all HEI’s use the same evaluation form for practise placements

	(developed together). The DCP steps are also included in this document, and this have been translated to English (e.g. for international placements). You can find them in attachment. Besides this, I can't think of anything else we could send you about the DCP. 2. Which current problems in implementation do exist? There is no formal or legal consensus about the process. Our ley only stipulated the task and actions a dietitian can perform, but not the process to be followed. Reference: own document of Belgium university: Copy of evaluation form for practice placements/internships
Germany	1. How is the use of the framework in your country? The G-NCP has been published 1 week ago and will be successively implemented by teaching the head of schools for dietitians and train the trainer programs 2. Which current problems in implementation do exist? See above. There are no problems because Germany is about to start the implementation of the G-NCP. However, the implementation will be monitored and evaluated by a standing working group at the German Dietitian Association which will also deal with problems that certainly will arise.
The Netherlands	<u>General</u> Following heuristics for designing diets (2013) Consists of three parts divided in multiple steps Including the ICF-model (International Classification of Functioning, Disability and Health) **DCP** <u>Preparation</u> - Study referral and client's health file - Gather relevant information <u>Dietary research</u> - Record client information - Define the client's need - Determine method of nutritional assessment - Analyse the nutritional assessment - Set the **dietary diagnosis** (ICF-model) <u>Dietary treatment</u> - Formulate goals of dietary treatment

	- Formulate features/demands of diet - Create a sample menu - Formulate a lifestyle advice - Determine if food supplements or dietary products are necessary - Examine which information material is relevant to provide - Describe steps/phases of dietary treatment plan - Evaluate dietary treatment - Write (if applicable) a start report and final report to referrer 2. Which current problems in implementation do exist? The heuristics of designing diets is developed by teachers (dietitians) from the HEI Groningen and thus only used by students of the HEI Groningen. However, 'Het Diëtistische Consult' is leading in all of the Nutrition and Dietetics educations.

b) Based on the results of the comprehensive descriptions of the four different DCPs (O2/A1) the strengths and weakness of these frameworks DCP were worked out.

These results are a summary of statements from the project partners. They are designed to think and discuss about important needs for the IMPECD-DCP.

A general remark:

- Strength & weakness should be on **all** models observed, to include: DCP from USA, UK, Germany, Belgium, Austria and the Netherlands
- There are 3 DCP Models posted on Trello form Austria and 2 models from the Netherlands. The model in 'Het diëtistisch consult' is leading in the Netherlands. Beside the Dutch model that has been uploaded on Trello another Dutch model has been published in 2010 by "Runia S, Tiebie J, Visser, V (2010): Dietistische diagnose onmidbaar bij effectieve behandeling. Ned Tijdschr voor Voeding & Dietetiek 65(3), 5 20-22.
- This paper is based on O2A4principalsontheDCP which describes a 4 steps DCP. The explanation for this is missing (e.g. it is the working model at the beginning and still could be changed), interesting questions (e.g. Groningen asked if a preparation step would make sense) are not discussed
- The question if a circle of flow chart is better for a model has not been discussed
- 4 Steps is making sense, however, none of the 4 models of each country have a 4 step model…

1. Strengths

- Clear structure in four or five process steps

- this is a strength if there is a rationale for four or five steps - is this by interviews, literature review,.... method for deciding how many steps are needed and is important!
- it is clear what information should be collected / documented in each step
- A comprehensive structure using clear, defined and uniform method of operating & reporting the dietetic care.
- The name "*DCP"* clearly defines under O2A4 for now, however we should open for rethinking.

· Nutritional diagnosis is essential in order to focus the nutritional struggles of a patient. It is also a critical part towards defining the intervention (e.g. treatment) needed.

· Monitoring and Evaluation shown in a circle (G-NCP and NCP)

2. Weaknesses

· In general:
  - Different types of structure (flow diagram vs. cycle)
  - Different types of title (NCP/DCP)
  - No description of content of different steps
  - different wording for process steps
  - too less best practice examples published how the process can be applied in practice for motivating dietitians for using the process as well
  - Different types of structure: Cycle vs. Flowchart -> no clear structure
  - Comparison between the 4 IMPECD countries only and not between all process model exciting in the world (NCP devolved in the USA and Dietetic and Nutrition Care Process developed in UK)
  - Based on what reasons is the 4 step model suggested
  - Some DCPs (eg. USA, GER, AUS) mention "screening and referral" at the beginning of the process and the "Outcome Management System" at the ending of the process.

· assessment:
  - Some process steps are not worded (missing steps e.g. patient needs and recourses)
  - deficient systematics of assessment methods and procedures
  - assessment differs depending on target group or individual, no description available
  - Re-Assessment is not mentioned
  - Re-assessment is part of the evaluation (e.g. evaluation and re-assessment) according to the Academy it does not belong to "nutrition assessment".

· diagnosis:
  - information about integration and interpretation especially between medical diagnosis and nutritional diagnosis not clear stated; problem of terminology

- causes are not denominated
- no system for diagnosing - eg. PES model hasn´t been published in Austria yet, application and limitations unclear
- no idea about how a good diagnosis could look like
- students and dietititans often use medical diagnosis instead of making own diagnosis
- unclear weather a dietetic/nutrition diagnosis needs to focus on parameters only the dietitian can change
- 2 different concepts of making a nutrition diagnoses: PES Statement (NCP) vs. G-NCP (PESR Statement); this is due to the Processes are based on different concepts; NCP (USA) is based on NCPT (formerly IDNT) and the G-NCP is based on the ICF; This is currently not addressed
- The difference between a medical and nutrition diagnoses is clearly stated in the NCP (USA), G-NCP and Dietetic and Nutrition Care Process (UK)
- The causes (ethology) of nutrition problems are clearly started in the NCP (USA) and without changes used in the G-NCP.
- the types of nutrition intervention are clearly stated in the NCP and defined in the NCP.
- Different types of nutrition communication (nutrition information, tailored nutrition information, nutrition counselling, nutrition education/instruction) are defined in the G-NCP Manual

· intervention:
- targets not clear defined
- information of communication and counselling is missed
- which theories are used (e.g. participation); standards in counselling
- no clear definition of interventions - consultation, therapy, information etc.
- definition of SMART goals often not applied - very rough idea of what dietitian plans to do
- Intervention with clear sub-categories is a necessity in order to clearly define the intervention part (e.g. Objectives; Regimen; diet prescription ….)
- the types of nutrition intervention are clearly stated in the NCP and defined in the NCP. Different types of nutrition communication (nutrition information, tailored nutrition information, nutrition counselling, nutrition education/instruction) are defined in the G-NCP Manual

· monitoring and evaluation:
- if dietitians use medical diagnosis instead of making their own one, they often can´t define monitoring / outcome parameters
- no definitions of outcome parameters to define successful therapy, since medical/pharmatherapy influences outcome as well...
- Should be clearly define what this part includes + includes the re-assessment + re-diagnosis + re-intervention

- Outcome Management System is not a part of the Monitoring and Evaluation step according to NCP or G-NCP

Conclusions

The results show that the status of use and implementation of DCP in the four countries differs from each other. The first impression is that all DCPs have weaknesses. This has to be taken into account while developing the model for IMPECD. It needs to be discussed on the 2nd transnational meeting in Fulda.

This summary is the output for the work package O2/A2 and milestone 2b.