

respectively ( $P < 0.001$  for doctors and nurses) and ( $P = 0.003$  for nurses and paramedical staff). Pittsburg Sleep Quality Index (PSQI) scale showed (36%) 'poor sleep' quality and (20%) 'need help' category. Perceived Stress Scale (PSS) showed (72.68%) were moderately stressed with compromised sleep quality.

**Conclusion** When BMI was compared with macronutrients and micronutrient, sleep and stress patterns results showed a positive correlation ( $r = 0.312$  ;  $t=4.679$ ;  $p < 0.001$ ). Indicating stress can influence body composition, nutrition intake and sleep quality.

## Health systems

### 17 AN EVALUATION OF NG REMOVAL PRACTICES AND NUTRITIONAL INTAKE PARAMETERS IN AN ACUTE NEUROSURGICAL POPULATION – THE DEVELOPMENT OF AN NG TRANSITION FEEDING PROTOCOL

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**Background** Due to the complex nature of neurosurgical patients, nasogastric (NG) tube feeding is often implemented to provide nutrition for patients unable to consume adequate oral intake. During recovery patients on enteral nutrition (EN) are progressed to oral nutrition (ON), which can quickly result in NG removal and discontinuation of an existing feeding plan. This is often before patients become established on sufficient oral intake to meet their nutritional requirements.

**Methods** We conducted a 3-month, prospective audit on 5 neurosurgical wards to answer 6 key questions related to commencement of ON and removal of NG tubes: (1) How long is average response time from initial speech therapist (SLT) to dietitian (RD) review once oral intake is commenced? (2) How long on average do patients keep NG in situ following commencement of ON? (3) Who is the main decision maker regarding NG removal? (4) How likely is a patient to meet their dietary target on the first review after NG removal, based on the decision maker? (5) Do particular SLT recommendations influence the likelihood of a patient meeting their dietary targets? (6) Does type of EN influence likelihood of patient meeting their overall nutrition targets?

**Results** After oral intake was commenced, only those receiving supplementary EN achieved nutritional targets immediately. Conversely, no patient who had their NG removed at this stage achieved these targets. Following NG removal, the likelihood of a patient meeting nutritional targets was influenced strongly by the decision maker, supporting the practice of RD led cessation of NG feeding. These findings led us to develop an 'NG Transition Feeding Protocol (TFP)' to serve as a simple, clear pathway which treating teams can utilise to guide NG feeding decisions.

**Conclusions** NG feeding supports neurosurgical patients to meet nutritional requirements in the early stages following commencement of oral intake. The development of an 'NG Transition Feeding Protocol' can help to improve consistency of transition feeding on neurosurgical wards, allowing adequate time for formal nutrition assessment to support

informed decisions around NG removal. This model may improve the efficiency of transition feeding, improve dietetic workload efficiency, nursing staff confidence and avoid compromising nutritional status of patients due to early cessation of EN.

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## Health systems; practical implementation

### 18 FINDING THE PLACE FOR NUTRITION IN HEALTHCARE EDUCATION AND PRACTICE

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**Background** Malnutrition continues to impact healthcare outcomes, quality of life and costs to healthcare systems. Implementing nutritional care requires knowledge and skills which dietitians are trained for, however due to their limited numbers they rely on other healthcare professionals to recognise, initiate treatment, and subsequently refer where necessary. This paper describes an iterative development and implementation of nutrition medical education resources for doctors and healthcare professionals in England through a project called Nutrition Education Policy for Healthcare Practice.

**Method** The interdisciplinary teaching team consisted of medical doctors, a registered dietitian, associate and registered nutritionists, a registered nurse, academic and education professionals. A two-stage process based on action research methodology was employed to develop and implement workshops. An initial pilot followed by 6 workshops reached 169 participants and delivered 13.5 hours of nutrition teaching. The workshops were evaluated using a combination of tools one designed by the NNEdPro team, others provided by the host organisations where the workshops were delivered. Further informal feedback during, and after, each road show was captured.

**Results** Formal feedback on the workshops using the workshop evaluation tools was limited. A key finding from workshop delivery included lower attendance for voluntary workshops compared to mandatory workshops. Better reception of workshops which were delivered by doctors known to the participants and included local issues, and increased difficulty in organising interdisciplinary education due to low priority given to nutrition, and uncertainty of the professional roles in the delivery of nutrition care.

**Conclusion** Although this project allowed successful development of resources for nutrition training of doctors and was successfully delivered and adapted, there was no clear "place" for this training in current healthcare teaching. One proposed way to change this is to demonstrate interprofessional roles through relevant clinical scenarios, aiming to align existing roles and workplace expectations as part of MDT, thus supporting dietitians in tackling malnutrition as a healthcare workforce.