awareness and practice makes for a healthy work force. Punjab, known as the food basket of India, ironically, suffers the prevalence of ‘malnutrition’. This, especially among rural women, is primarily due to lack of nutritional awareness and education. With this premise, a Basic Nutrition Curriculum Development intervention was conducted with rural women in Punjab.

Methodology The nutrition intervention involved 35 trainees pursuing beauty care and stitching training at a charitable trust (MBCT). A 10 sessions’ curriculum @2.5 hours each was delivered on a weekly basis and documented using pre and post sessions’ questionnaires (Knowledge, Attitude, Practices methodology). A Review was undertaken after three months of the completion of the intervention. Participatory activity-based pedagogy using audio-visual aids and live demonstrations were used. Select ingredients were also given to the trainees.

Results Significant post-attendance changes were observed in the trainees. They had gained awareness about basic food groups, the balanced food platter etc. Notable changes in their daily eating habits – eating at the right time, appropriate water consumption, including different food sources in diet were observed. The intervention also made the respondents rethink their assumptions based on customary beliefs and practices. Mindfulness of cooking practices and use of appropriate quantity of cooking oil was observed. Importantly, awareness about causes and symptoms of nutrition related deficiencies and appropriate foods to overcome them was also noted. The trainees also gained confidence to discuss their health problems with family. Knowledge sharing with peer group and family members was also observed as trainees used the recipe book containing dishes prepared during the training.

Way forward The aim is to advocate the Basic Nutrition Curriculum’s adoption gender-neutrally as a compulsory component in all Skill Development Programmes run by government, non-government (NGOs) and private institutions under the Punjab Skill Development Mission.
respective (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

Abstracts

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 leading 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.

Acknowledgements We would like to acknowledge the Nutrition Education Policy in Healthcare Practice (NEPHELP) secondary care group for their consultation on this project.

Health systems; practical implementation

18 FINDING THE PLACE FOR NUTRITION IN HEALTHCARE EDUCATION AND PRACTICE

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 who 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.