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How to Organize the Dietetic Service in a Hospital

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Disease related malnutrition is a well-documented problem in almost all countries, but the organization of the nutritional support is extremely varying. In Denmark we have a national quality indicator showing the use of screening for malnutrition within the initial 24-48 hours after admittance, in other countries other systems are used. The question now arises, when should a dietician be attending the patient? or should the nutritional care be part of the general nursing obligations? In Denmark the nurses have taken over most of the nutritional obligations, and we have no generally accepted guidelines for the use of dieticians. They are called upon as needed, but what does that mean?

From observational studies we know, that the majority of the patients classified as malnourished experience further weight-loss during hospital stay [1], and that malnutrition is associated with increased risk for both infectious- and thrombotic complications, prolonged length of stay in hospital, increased frequency of re-admittance after discharge and increased use of institutions after discharge [2-5]. In addition, we know that malnourished patients cost 42 % - 102 % more than well-nourished [6].

Randomized intervention studies have shown the effect of nutritional therapy using oral supplements and tube feeding [7], but randomized studies on the organization of the nutritional support are extremely few. The only randomized and blinded study published showed, that a visiting team of a dietician and a nurse with special interest in nutrition resulted in a significant improvement in the intake of both energy and protein and resulted in fewer complications [8]. The team attended the patients screened positive for malnutrition (NRS-2002) on a daily or nearly daily basis during hospital stay. In an unpublished, randomized, intervention study presented at the ESPEN Congress 2017 [9] it is shown, that the re-admittance rate for lung patients is significantly reduced, and that the intake of both protein and energy is significantly better, if a dietician takes care of the nutritional therapy during hospital stay instead of the nurses, as was the routine in that particular hospital.

We really need further documentation in the form of randomized trials concerning the organization of nutritional care in our hospitals. Apart from the quality of the nutritional therapy, there are severe financial implications. In Denmark the hospital services are tax paid, but some of the expenses are to be paid by the region (in-hospital costs), and the costs after discharge are paid by the municipalities. In the national, overall budget the savings in this study is much larger than the salary for the dietician. In other financial systems this may be different, and savings should be related to the same account as the expense, if the financial incitement should be present. There is probably only little doubt about the nutritional benefits in a more qualified organization.

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