Setting goals with patients at risk of malnutrition: A focus group study with clinical dietitians

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1. Introduction

Although the risk of malnutrition frequently occurs in patients with complex conditions [1–4], the process of goal-setting with these patients has received little attention in research [5–9]. Globally, it is estimated that up to 50% of all inpatients have malnutrition [10–12]. Shared decision-making (SDM) is defined as a process jointly undertaken by patients and healthcare professionals in which best clinical evidence and decision-making (SDM) is defined as a process jointly undertaken by the patients’ lifeworld, values and preferences are considered [8,9,13]. Involving patients in their healthcare has been shown to promote patients’ motivation and increase the quality of care [9,14–17].

The risk of malnutrition is common in patients with diagnoses such as kidney, neurological, gastrointestinal and lung diseases, and cancer, especially in older patients with frailty [1–4,18–20]. Various factors increase the risk of malnutrition, such as reduced food intake due to eating difficulties, depression, aging, increased metabolism, catabolism or malabsorption [1–4,18–20]. Hence, effective malnutrition interventions require efforts from diverse healthcare professionals [10,21–23], with dietitians playing a significant role [19,24–27]. The role of dietitians is to assess patients, diagnose nutrition problems, plan nutrition interventions, and monitor and evaluate these interventions in collaboration with the patient [28–32]. The identification of nutrition...
intervention goals is important to enable monitoring and evaluation of outcomes. Nutrition intervention might entail increasing energy- and protein density through appropriate food choices or enrichment of foods [24–27], modifying food consistency, increasing frequency of meals, prescribing oral nutritional supplements (ONS) or use of enteral or parenteral nutrition [19,33,34]. Improvements in quality of life and functional status are also pursued [27,33,34].

In the past decades, person-centered care has been increasingly described in dietetic research [19,30,31,35–37]. Since many patients at risk of malnutrition are cared for at home, additional attention to supporting self-management is warranted [3,5]. Setting goals collaboratively with patients increases their sense of control over their health and the chance of achieving and sustaining goals [38,39]. In nutrition interventions, patients’ engagement and motivation are essential to achieving long-term goals [40–42]. According to patient laws in Sweden (2014:821), healthcare professionals must consider patients’ integrity and facilitate patient participation in the care [43]. However, knowledge about SDM and models for its use in goal-setting are lacking, not least in nutrition care [9,30,35,37]. Frequently used models for SDM focus on action plans whereby the patient’s choice is emphasized, different treatment options are discussed, and actions are agreed upon with the patient [9,15,16]. Selecting the most relevant action plans adjusted to the patient’s situation and needs requires elucidation of the patient’s goals [8,9,13], otherwise patients and dietitians may have different or even contradicting goals [8,9,13,30]. While there is research focusing on patients’ perceptions of goal-setting, less attention is given to the practice of goal-setting in clinical contexts and from the professional’s point of view [44]. There is also a need for evidence supporting the best practice of SDM in goal-setting in the clinical encounter [8]. Hence, the present study aimed to gain an understanding of the clinical dietitian’s reflections regarding the process of goal-setting with patients at risk of malnutrition.

2. Methods

2.1. Study design and participants

Focus groups with dietitians were used to gain knowledge about their shared experiences [45–47]. An inductive theoretical approach based on critical realism was used [48]. The inclusion criteria were dietitians with at least one year’s experience of working with inpatients or out-patients at risk of malnutrition and working at least 50% of full-time. Using purposive sampling [49], dietitians from three regions in central Sweden and various settings, primary care, district hospitals, and University hospitals, were invited to participate, covering areas with different socio-economic status to promote informative discussions and obtain diverse groups.

2.2. Data collection

The first author presented information about the study orally to dietitians at their regular meetings in two hospitals and one primary care setting. Focus groups were held in meeting rooms at the dietitians’ place of work, with one held at the University. All focus groups were audio-recorded and were co-moderated by the first author [removed for blind peer-review] and co-author [removed for blind peer-review]. The moderators [removed for blind peer-review] were introduced as registered dietitians and researchers interested in the process of evaluation of nutrition interventions for patients at risk of malnutrition. Demographic data were collected through a short questionnaire developed by the research team (appendix B). Two focus groups included additional questions specifically addressing stroke and risk of malnutrition; these questions were not included in the analysis since they did not match the generic focus of this study. We recruited 6 groups with 3–6 participants per group, as recommended in the literature, to enable informative discussions [50,51]. The sample size was considered adequate after six focus groups since the identified themesrecurred in all groups and no additional information was generated [50–53].

2.3. Interview guide development

A semi-structured interview guide (appendix A) was used allowing participants to discuss freely and share their thoughts within the framework of the topic. The interview guide was based on current literature concerning monitoring and outcome evaluation, goal-setting in nutrition interventions, person-centeredness in healthcare, risk of malnutrition, and the nutrition care process [10–12,46,54–56] as well as the research group’s knowledge about malnutrition interventions and dietetic professional practice, gained through clinical work or research [57–60]. A pilot focus group (n = 3) was conducted; this resulted in only minor changes to the interview guide and was therefore included in the final analysis. All dietitians were asked to reflect on their practice of goal-setting in nutrition interventions, the needs and desires of patients at risk of malnutrition, and patient involvement in the intervention.

2.4. Ethical approval

The study was approved by the Swedish Ethical Review Authority, Dnr 2019-02568. All participants received oral and written information about the study and provided written informed consent.

2.5. Analysis

The analysis process was ongoing during and after data collection. The focus groups were transcribed verbatim by the first author [removed for blind peer-review] and verified against the audio-recording. All focus groups were analyzed to identify patterns of shared meaning and themes in the data following the 6-phase guidelines of Braun and Clarke [61,62]. The transcripts were read several times to generate codes, consider initial themes, and for deeper review. Conceptualized themes, which were discussed and agreed on by all authors throughout the process, were defined. Although the focus was on the participants’ shared experiences, the reflexive thematic analysis was also enriched by including other perspectives during the analytic process, and exploring and interpreting the transcripts from cultural, linguistic and narrative perspectives [62,63]. The program Nvivo 11 (Qualitative Software for Research (QSR) International 2017) [64] was used in the coding process and systematic identification of themes.

2.6. Reflexivity

All the authors have wide knowledge about malnutrition interventions, dietetic professional practice, qualitative research and development of questionnaires and interview guides. In qualitative research, the researcher is considered as the instrument for data collection, analysis and interpretation [61,62]. Hence, the authors’ backgrounds and combined experience have informed the method used in this study. The first author and moderator have been trained in qualitative data collection. Open-ended questions were used to elucidate the dietitians’ reflections and avoid controlling the discussions. Participants were encouraged to talk freely within the topic, with minimum interference from the moderator. To enhance trustworthiness, each step of the 6-phase guidelines of Braun and Clarke was conducted thoughtfully, and conceptual themes were critically and extensively discussed by all authors to obtain a richer and more nuanced analysis of the data [62]. The first author and moderator [removed for blind peer-review] conducted all focus groups to ensure consistency of the study.
3. Results

3.1. Participants and focus groups

Six focus groups with three to eight participants/group were conducted (approximately 90 min/group) between June-December 2019. In total 29 registered dietitians from three primary healthcare settings and five hospitals in three regions in central Sweden participated (appendix B); the majority were women. All had experience of working with malnutrition interventions for either inpatients (10%), outpatients (38%), or both (52%). Most had working experience of over 10 years (70%). All had a bachelor’s degree in dietetics, about a third had a master’s degree and one a Ph.D. One dietitian participated twice, the second time specifically to add her reflections concerning stroke patients. The focus groups were dynamic and all participants expressed their reflections on the topic. Brief quotes from the participants are presented in the results, more detailed quotes are found in appendix C.

3.2. Exploring patients’ narratives, resources, and capabilities

Dietitians described exploring patients’ narratives concerning their past, current and desired health situation. Many stated that the patient’s previous weight and current eating preferences and habits affect the patient’s goals in malnutrition interventions. They problematized patients’ views on ideal weight, which they saw as being influenced by the social norm of slimness [65]. Hence, participants underlined that many patients who may have previously struggled with overweight view weight loss as positive. Some highlighted that such patients may resist selecting protein- and energy-dense foods since national recommendations for healthy persons, and information on social media about healthy diets, oppose this advice.

“I often think it can be difficult when patients are used to hearing that you have to be so healthy, and when they have problems eating and start losing weight, this eating healthily thing, it’s so strong so that they don’t want to make any changes because they’re afraid it won’t be good […]” (Group B)

Dietitians reflected on patients’ capabilities, ranging from physical, intellectual, social, and economic, and which vary depending on age, underlying medical diagnosis and its severity. They also described assessing food and nutrient intakes, health status, and health literacy. For severely ill patients, reducing anxiety and pressure around eating was highly prioritized by many of the dietitians. Physiological symptoms such as nausea, loss of appetite, pain, or taste alterations may, according to the dietitians, reduce patients’ abilities to make dietary changes. In addition, the primary care dietitians indicated that resources, such as a patient’s economic situation, can play a major role for patients and must also be considered.

Hence, exploring patients’ resources and capabilities was stressed as necessary to be able to set attainable goals. Patients may not articulate goals or thoughts about the optimal diet to match their needs, yet dietitians agreed that through exploring patients’ narratives, the patients’ personal goals can be elucidated.

3.3. Different skills and approaches when counseling patients

Acknowledging the prerequisite in healthcare of involving patients in goal-setting, the dietitians nevertheless struggled with implementing this in practice and described different approaches for counseling on goals and action plans. Some agreed on adjusting the counseling to patients’ resources and capabilities, while others suggested an approach that could be seen as more paternalistic, reflecting the asymmetric power distribution between patient and dietitian.

“[…] Maybe difficult for the patient but also nice for them to hear some guidelines, this is what you have to contribute, if you can’t manage it then we’ll stop.” It can be used as a good motivation although it can be difficult for the patient.” (Group D)

Some seemed unsure about the difference between goals and action plans, reflecting a need for common definitions. These dietitians described action plans, such as frequency of food intake, ONS/day, or amount of enteral/parenteral nutrition, as sub-goals, while others underlined the differences.

“I’m usually careful to set treatment goals and not set the action plan as a goal […] If that at the beginning of my career, drink two oral nutritional supplements a day, no, that’s not a goal that’s a way to reach a goal” (Group E)

Goals such as increasing weight, obtaining weight stability, and satisfying nutrition requirements seem to be prioritized in the nutrition intervention since the participants stressed that these were regularly documented in the electronic health record (EHR). However, documentation of patients’ goals was described as being often omitted. Even though the EHR may not reflect patients’ personal goals, dietitians emphasized the necessity of discussing these in the consultation in order to negotiate and agree on goals. Although they described informing patients about the optimal diet for their situation and needs, counseling patients on intervention goals was highlighted as lacking in practice.

The dietitians’ reflected that their repertoire of SDM skills is essential for implementing collaborative goal-setting as is competence in identifying patients’ goals and discussing intervention goals.

3.4. Discrepancy in goals and the asymmetric power distribution

Participants highlighted a discrepancy between their clinically-oriented goals and patients’ personal goals. They described the process of setting feasible goals with patients at risk of malnutrition as challenging and underlined interactional dilemmas when goals were contradictory. The asymmetric power distribution was illustrated whereby some dietitians described knowing better which goals to set based on their experience and knowledge, citing aspects that patients may not be aware of because they lack expertise.

“It can be challenging to get the patient to agree on a reasonable goal… some patients want to continue to lose weight because they’re overweight but there are patients who, yes, now I’ll gain 10 kg […] but in the situation they’re in, they have an incurable cancer, weight gain won’t be a reasonable goal and you say that in a respectful way without making the patient give up” […]” (Group D)

Patients’ goals were often outlined as “unrealistic” and “unattainable”, showing how the dietitians take on an expert role and indicating an ambivalence towards patients’ goals. Some highlighted the necessity of guiding patients towards feasible goals since patients lack knowledge and expertise. These dietitians stated that many patients are receptive and in agreement, while others highlighted that if goals are not adjusted to patients’ needs and preferences, patients may not adhere to the dietary prescription.

“Officially, we have person-centered care so that the patient should actually suggest what their goals are, but if I’m completely honest, it’s usual that you take over a bit, […] you have an idea about what is reasonable because I think many patients have completely unreasonable goals and then I can’t really wait for the patient to say what their goal is” (Group D)

They agreed that, for inpatients, the risk of malnutrition is difficult to resolve and the challenge of achieving long-term intervention goals was discussed. These patients have complex needs, encounter different healthcare professionals, and may move between different healthcare settings. However, most dietitians stressed the importance of involving patients in goal-setting for successful treatment. They indicated that if
goals are not negotiated, the discrepancies between dietitians’ and patients’ goals remain, and progress in the intervention will be less likely. Dietitians acknowledged their role in motivating patients, individualizing the intervention, and involving patients in goal-setting. Some stated that the focus group gave them new insights into the topic and increased their motivation to “think about other goals, really think about patients’ goals.” (Group B).

4. Discussion and conclusion

The focus groups highlighted the dietitians’ reflections concerning goal-setting in malnutrition interventions. Dietitians expressed striving to explore patients’ narratives, capabilities, and resources before setting goals. They described different strategies in counseling patients and a lack of patient participation in the goal-setting. They emphasized the difficulties of setting feasible goals due to discrepancies between their clinically-oriented goals and patients’ personal goals.

4.1. The asymmetric power distribution

SDM implies that both patients and professionals agree on goals and collaboratively find strategies to implement these [66]. Although dietitians possess evidence-based knowledge, patients are experts on their own lives and situations [14]. Strategies that work for patients might not, however, be optimal from a professional viewpoint [67]. Findings reflected an asymmetrical power distribution in the clinical encounter, whereby patients are dependent on the dietitians’ expertise and given less influence in the goal-setting process. There was uncertainty regarding patients’ knowledge and competence, which was interpreted in expressions such as “unrealistic goals”. Many studies have identified and discussed the power between dietitians and patients [19,31,42]. It has been suggested that implementing person-centered care, and establishing SDM with the patient, can compensate for this imbalance [19,31,42]. However, the dietitians’ repertoire of SDM skills is essential to enable implementation.

Many patients prefer not being active, having been socialized into thinking that dietitians know better and trusting the dietitian’s competence [68]. This power inequity inhibits patients from believing that they can be involved in the decision-making process [68]. However, if goals do not correspond to the patient’s lifeworld, the patient might not manage to adhere to the nutrition prescription [44]. Although intervention goals usually require changes in eating habits, these are often set regardless of whether the patient is motivated to change or not [69]. Failure to adjust the goals to patients’ preferences and level of motivation may lead to ineffective interventions.

In severe illness, patients may not be receptive to information due to emotions such as anger and sadness [70], which will also affect their ability to engage in the process of goal-setting. The quality of care is reduced if the consultation involves goals reflecting the professional’s expertise and priority rather than the patient’s emotions and values [44, 70]. However, intervention goals, such as weight stability, can promote patients’ motivation to change weight. Failure to adjust the goals to patients’ preferences and level of motivation may lead to ineffective interventions.

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4.2. Strategies to bridge the gap

The findings in this study highlight that dietitians seem to lack routines, education, and tools to overcome the discrepancies between goals in malnutrition interventions. The essence of SDM in goal-setting is to elucidate the professionals’ and the patients’ perspectives, then negotiate and collaboratively agree on feasible goals. For this to occur, dietitians need to acknowledge patients’ expertise and involve them in the goal-setting process. Qualitative studies have indicated that training in communication and person-centered care result in increased confidence in involving patients in decision-making and the goal-setting process [30,37,41,71]. Patients may not have defined goals but, through sharing their narratives, patients’ implicit goals might be understood [39]. Education and training in SDM, and relevant tools, may encourage this explication of goals and support dietitians in counseling patients about goals. Lenzen et al. developed a conversation approach to support nurses in exploring patients’ experiences of their condition and facilitate a dialogue about patients’ current and desired situations [9]. Since the tool is generic, it could also be used in nutrition care in malnutrition interventions. Instruments, such as the Goal Hierarchy developed by Berntsen et al., can also be used to help dietitians translate patients’ personal goals into feasible intervention goals [72]. However, it is important to underline that there is no checklist to support the implementation of SDM since each clinical encounter is unique [73]. Implementing SDM in goal-setting requires dietitians to constantly reflect on their practice. This process can be promoted through training dietitians in questioning their routines and finding new strategies to improve nutrition care [16,66,74,75]. Validated tools can be used to evaluate patient-centered practices and identify areas requiring improvement [16,75]. Motivational interviewing (MI) can be used to encourage patients’ motivation to change [16]. When patients feel empowered and motivated, it can be easier to negotiate, identify and elucidate the patients’ goals. Since both motivational interviewing and SDM are person-centered methods, we propose the use of a combination of strategies [16,17,37].

4.3. Shared decision-making in goal-setting

Malnutrition requires long-term interventions and the risk of relapse is high [24]. Hence, to promote patient involvement across the continuum of care and identify feasible goals [13], the explication of patients’ goals is necessary, both in oral communication and in EHR documentation. In nutrition care, dietitians should identify, discuss, and set goals collaboratively with patients, and evaluate and follow these up [76]. However, if dietitians focus on action plans, nutrition intervention outcomes cannot be evaluated. Evaluation is necessary to improve the quality of interventions in healthcare and provide patient-safe care. Before deciding on action plans, Lenzen et al. suggest three steps in the process of goal-setting [9]: exploring patients’ current and desired situations, giving information tailored to the patient, and supporting the patient in formulating feasible goals.

Since the patient’s situation may change due to their condition or medical treatment, goal-setting should be seen as a continual process from one consultation to the next. When assessing patients’ current situations and needs, it is necessary to explore patients’ resources and capabilities otherwise selecting feasible goals is impossible. In an interview study on perceptions of illness identity, patients with cancer struggled between different identities concerning the past, present, and future when making treatment decisions [77]. Hence, patients’ experiences, values, and goals are correlated with their perceived identity. According to the principles of person-centered care, patients’ values and identities are shown through their stories [14]. Exploring patients’ narratives is also necessary when adjusting goals. In flexible interactions, the patient’s involvement is promoted in the counseling. Informing patients entails giving instructions whereby the patient becomes a receiver of facts [78]. However, counseling involves an equal relationship between the healthcare professional and patient, aimed at supporting and empowering patients [79]. Hence, evidence-based counseling tailored to the patient is more compatible with the viewpoints of SDM rather than giving information tailored to the patient as suggested by Lenzen et al. [9]. When patients understand how their lifestyle affects their condition and their role in self-management, they become more independent and changes are more likely [80]. A person-centered interaction involves a dialogue where patients’ knowledge and expertise, and professionals’ evidence-based expertise...
are equally considered [17,81]. Lenzen et al. suggest supporting patients in formulating feasible goals before deciding on action plans [9]. However, from our findings, patients’ and dietitians’ goals should be explained. Feasible evidence-based and realistic goals, and patients’ personal goals based on their preferences, should be communicated and negotiated. Explicating and negotiating feasible goals matches the concept of SDM and highlights this interaction. Since patients at risk of malnutrition have complex needs, implementing the above-mentioned steps may support professionals and patients in prioritizing between different treatment options and facilitate the goal-setting process.

4.6. Practice implications

Discussions in focus groups do not represent direct reflections of the individual participants’ actions or opinions [63], but rather a desired or normatively accepted reality constructed by the participants in a certain social context [82]. As well as this epistemological aspect, other practical aspects should also be considered. Since, for practical reasons, most of the focus groups were held at the dietitians’ place of work, many of the participants knew each other. Participants were also acquainted with the research group since the dietetic corps in Sweden is small and many are aware of ongoing research nationally in this area, which may have influenced the discussions. However, the focus groups included participants with experience from various settings, which promoted valuable discussions. Complementing findings with patient interviews and recruiting from other regions in Sweden might have provided more information. The trustworthiness of the study was ensured by standards such as applicability, consistency, credibility and neutrality [62,63,83].

4.5. Conclusion

The dietitians described a lack of patient involvement in goal-setting and discrepancies between dietitians’ goals and patients’ personal goals. Goals need to be negotiated to correspond with patients’ capabilities and resources. The dietitians’ repertoire of SDM skills is essential to actively involve patients in the intervention and balance the asymmetric power distribution. To bridge the gap and promote person-centeredness, education in SDM, and strategies and tools to support dietitians in involving patients in goal-setting, are warranted.

4.6. Practice implications

The findings may be used to develop and utilize tools and strategies, and construct studies on the implementation and education of SDM in goal-setting for malnutrition interventions. Such studies need to provide more precise insight into dietitians’ reflections on the practice of SDM. We suggest further research focusing on patients at risk of malnutrition with different underlying diagnoses to identify specific aspects concerning these patients, and research on different types of goals in malnutrition interventions.

Ethics approval and consent to participate

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CRediT authorship contribution statement

Lina Al-Adili: Conceptualization, Methodology, analysis, Investigation, Writing – original draft preparation. Jenny McGreevy: Conceptualization, Methodology, analysis, Investigation, Writing – review & editing. Ylva Orreval: Conceptualization, Methodology, analysis, Supervision, Writing – review & editing. Margaretha Nydahl: Conceptualization, Methodology, analysis, Supervision, Writing – review & editing. Anne-Marie Bostrom: Conceptualization, Methodology, analysis, Supervision, Writing – review & editing. Elin Lovestam: Conceptualization, Methodology, analysis, Supervision, Writing – review & editing, Project administration.

Author contribution

All authors have participated in the conception and design of the study, as well as the analysis and interpretation of the data. Lina Al-Adili and Jenny McGreevy performed the data collection. Lina Al-Adili was responsible for drafting the manuscript; all authors contributed with critical revisions and supervision.

Conflicts of interest

Declarations of interest: none. The authors declare no conflicts of interest.

Transparency declaration

The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported. The reporting of this work is compliant with COREQ guidelines. The lead author affirms that no important aspects of the study have been omitted and that any discrepancies from the study as planned have been explained.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2022.02.015.

References


