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Dietitian staffing levels In Ontario Hospitals

A report from the Dietitians of Canada Ontario Clinical Nutrition Leaders Action group (CNLAG)

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Executive Summary

Dietitians of Canada's (DC) Clinical Nutrition Leaders Action group (Ontario) surveyed DC members working in acute care settings in the fall of 2017 to collect information on current staffing levels of in- and outpatient programs across Ontario. This survey is the first of its kind in Ontario and serves as a baseline dataset for future work in determining optimal hospital dietetic staffing levels.

Twenty-one dietitian professional practice leaders responded to the survey. The largest hospital to participate had 1250 inpatient beds, and the smallest had 42. In total, the findings of this study represent 7,692 inpatient beds in Ontario and nearly 23,500 outpatient monthly clinic visits.

Highlights of the survey responses:

- Registered Dietitian (RD) staffing is widely variable among the responding hospitals
- RD FTEs per 100 inpatient beds ranged from 1.0 – 5.0
- Total RD staff complement ranged from 0.4 - 40.0 FTE RDs in participating institutions
- The most common staffing ratio among participating hospitals was 2.0 RD FTE per 100 beds
- Nutrition screening is being conducted on admission in 40% of the institutions surveyed, but not consistently. Screening is performed by various staff, and only 1 hospital reported screening was performed by an RD
- Fifty percent of respondents indicated that their institution provided casual RD coverage for vacation and sick time, range = 1.0 FTE casual RD per 12.5 FTE RDs or 0.02 FTEs per 100 beds
- Diet tech support reported in a range of 1.0 FTE diet technician per 100 inpatient beds to 1.0 FTE diet technician per 2000 inpatient beds. Six respondents had no diet technician services. The role of the diet tech position varied greatly with only some supporting the RD.
- Professional Practice leader (PPL) role: Two sites did not have a PPL role. For those hospitals that do have the role, time allotted varied from 1 FTE per 100 RDs at the lowest part of the range to 1 FTE per 10 RDs at the highest part, (0.2 – 2.0 FTE per 100 inpatient beds)
- Training of interns varied from 1 week or less per RD FTE, to some RDs acting as preceptors for interns for 6 months of the year every year. This is a considerable variation in support of the future of the profession.
- The number of patients on enteral and parenteral nutrition support was used as an indicator of patient acuity, based on the expert opinion of the guiding group. Survey respondents reported 0 – 150 patients per day on Enteral Nutrition Support, and a range of 0 – 90 patients per day on Parenteral Nutrition Support.
- Survey respondents assessed levels of dietetic staffing as inadequate to provide appropriate nutrition care, particularly in inpatient units.

Impact on Patient Care and Dietitian Practice

Lack of screening for nutrition risk is likely leading to missed opportunities for nutrition care and for effective use of dietitian time, and ultimately to poorer outcomes, increased length of stay and in some cases, readmissions. Many patients are discharged before they can be seen or assessed by the dietitian, have follow up arranged or patient education completed.

There is generally a lack of coverage for dietitians' vacation and sick time. Even in cases where there is designated casual relief it is often insufficient or can only be used for planned absences or vacations. Dietitian absences left uncovered exacerbate the staffing issues already present, leading to even higher numbers of patients without access to dietetic care.

Dietitians find they are restricted to providing care only for the highest priority patients, leaving others to become more vulnerable as their hospital stay goes on. Some respondents described the loss of the diet technician role and the impact this has had on nutrition screening, menu customization and follow up for patients. Respondents described their inability to attend rounds, care conferences, follow up with family or provide patient education. Some respondents spoke of increased levels of acuity as well as added services and clinics with no additional increase to RD time. These situations lead to frequent unpaid overtime, missed care opportunities and risk of burn out. Further investigation is warranted to better understand methods of mitigating RD burnout and overwork in all clinical nutrition areas.

The following chart shows the range of staffing levels per in- and outpatient units reported by survey respondents, converted to FTE per 100 beds and FTE per 10 beds. Respondents' assessment of the adequacy of dietitian staffing for the unit is represented as Yes/No, and, where applicable, different opinions of adequacy of staffing from different hospitals.

Dietitians Staffing levels -- Inpatient units

Clinical Area/Unit	FTE Per 100 beds	FTE Per 10 beds	Considered sufficient by survey respondents? (Yes/No)
Total RD staffing	2.0 average, range 1.0- 5.0	0.2 average	
Casual RD coverage	0.02 average	0.0002 average	
Diet technician	0.05 – 1.0	0.005 – 0.1	
Professional Practice Leader	0.2 – 2.0	0.01 – 0.2	
Unit-specific Dietitian staffing			
General Medicine	1.0 - 2.5	0.10 – 0.25	N
Oncology and Palliative Care	1.1 – 1.6	0.11 – 0.16	Y Palliative, N for Oncology
Complex Continuing Care	1.2 – 1.6	0.12 – 0.16	N
Cardiology	0.5 – 1.0	0.05 – 0.10	N
Intensive Care Unit	2.0 – 5.0	0.2 – 0.5	Split Y/N
General Surgery	0.8 – 3.0	0.08 – 0.3	N

Clinical Area/Unit	FTE Per 100 beds	FTE Per 10 beds	Considered sufficient by survey respondents? (Yes/No)
Nephrology	2.0 – 5.0	0.2 – 0.5	N
Orthopedics	0.6 – 1.0	0.06 – 0.1	Y
Stroke/Neurology	0.9 – 2.0	0.09 – 0.2	N
Rehabilitation	1.0- 2.0	0.1 – 0.2	N
Neonatal Intensive Care Unit	1.1 – 8.0	0.11 – 0.8	N
Alternate Care Unit	0.5 – 2.0	0.05 – 0.2	N
General Pediatrics	1.3 – 1.4	0.13 – 0.14	Y
Obstetrics	0.13 – 0.2	0.013 – 0.02	Y
Mental Health	0.5 – 1.0	0.05 – 0.1	N

Dietitian Staffing levels -- Outpatient units

Clinical Area/Unit	FTE Per 100 beds	FTE Per 10 beds	Considered sufficient by survey respondents? (Yes/No)
Diabetes Education/Complex Diabetes Care	0.4 – 3.0	0.04 – 0.3	N
Oncology	0.2 – 1.4	0.02 – 0.14	Split Y/N
Nephrology	0.2 - 1.3	0.02 – 0.13	Split Y/N
Mental Health	0 - 1.2	0 – 0.12	Y
Obstetrics/Antenatal	0.6 – 2.1	0.06 – 0.21	Y
General Medicine/Surgery an GI Medicine/Surgery	2.0 – 3.0	0.2 – 0.3	Split Y/N
Cardiology	0.05 – 4.0	0.01 – 0.4	Y
Complex Continuing Care	1.2 – 1.6	0.12 – 0.16	N
Cardiology	0.5 – 1.0	0.05 – 0.10	N
General Pediatrics	0.8 – 2.0	0.08 – 0.2	Split Y/N
Transplant	0.06	0.01	Y
Neurology/Stroke	0.25 – 1.6	0.03 – 0.16	N

Recommended Next Steps:

- Determine strategies for further data collection on dietitian staffing
- Explore partnerships with other stakeholders to facilitate data collection and analysis
- Explore differences in dietitian roles and practice, and patient outcomes, related to varying levels of staffing
- Investigate rationale or criteria for assessment of “sufficient” and “insufficient” dietitian staffing, as a first step to developing best practices and staffing standards

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Dietitians of Canada / Les diététistes du Canada
480 University Avenue, Suite 604
Toronto, Ontario, Canada M5G 1V2

TEL: 416.596.0857
FAX: 416.596.0603
EMAIL: contactus@dietitians.ca

www.dietitians.ca | www.dietetistes.ca