

Checklist to identify and address barriers to screening and assessment

Barrier	Tips to address barriers
Perceived lack of evidence to support practice	<ul style="list-style-type: none"> <input type="checkbox"/> <u>Refer to key evidence-based guidelines:</u> <ul style="list-style-type: none"> - COSA cancer-related malnutrition and sarcopenia position statement¹ - Updated evidence-based practice guidelines for the nutritional management of patients receiving radiation therapy and/or chemotherapy² - Evidence based practice guidelines for the nutritional management of adult patients with head and neck cancer³ - ESPEN guidelines on nutrition in cancer patients⁴ - Oncology evidence-based nutrition practice guidelines. Academy of Nutrition and Dietetics⁵ - Sarcopenia: revised European consensus on definition and diagnosis⁶ - Sarcopenia: A time for action. An SCWD position paper⁷ <input type="checkbox"/> <u>Gather key opinion leaders to support implementation</u> - for example clinical leaders within the multidisciplinary team.
Not a priority for health service	<ul style="list-style-type: none"> <input type="checkbox"/> <u>Gain leadership buy-in and engagement</u> - for example clinical leaders within multidisciplinary team and/or hospital executive. <input type="checkbox"/> <u>Identify local barriers and enablers</u> - Identification of barriers and enablers to malnutrition and sarcopenia screening and assessment at individual, team and system levels is the first step to facilitate adherence to evidence-based nutrition care recommendations and policies (refer to implementation section of toolkit for details on how to do this). <input type="checkbox"/> <u>Involve the quality department</u> – develop local key performance indicators and relevant audit schedule. <input type="checkbox"/> <u>Collect local data</u> – The audit tool in the toolkit can be used to show adherence to the COSA position statement recommendations. Use clinical data such as malnutrition or sarcopenia point prevalence survey data to highlight the need. If it's not available, make a plan to collect this data.
Low clinician awareness and understanding	<ul style="list-style-type: none"> <input type="checkbox"/> <u>Train relevant clinicians</u> - Utilise freely available training and incorporate into local training packages for clinicians: <ul style="list-style-type: none"> - COSA cancer-related malnutrition and sarcopenia implementation toolkit - Malnutrition and Sarcopenia in Cancer eLearning program on Cancer Institute NSW eviQ website¹³ - Existing videos such as The Importance of Nutrition to Prevent and Treat Low Muscle Mass - YouTube - CanEAT pathway¹⁴ resources available at www.petermac.org/caneatpathway
Lack of local policies/ procedures/ pathways	<ul style="list-style-type: none"> <input type="checkbox"/> <u>Map local workflows</u> - Consider incorporating screening for malnutrition and sarcopenia into existing multidisciplinary and/or supportive care screening processes or patient-reported outcomes to aid ease of completion and compliance, reduce the need for additional resources and to support the initiation of appropriate assessment and care. <input type="checkbox"/> <u>Care pathways</u> - Consider use of care pathways to support delivery of optimal patient care (see generic pathway and/or examples given in upper GI exemplar). <input type="checkbox"/> <u>Local governance</u> - Malnutrition/sarcopenia screening and assessment should be incorporated into the appropriate nutrition care policy directives with local governance, management committees and performance review processes embedded to support successful and sustainable implementation.

	<input type="checkbox"/> <u>Malnutrition governance toolkit</u> ⁹ - utilise this toolkit to support development of local policies/procedures, key performance indicators and other governance supports.
Insufficient pre-existing processes	<input type="checkbox"/> <u>Build your team</u> - Ensure you have good multidisciplinary buy-in and specific strategies to maintain their engagement. Consider clinical champions to help your efforts. <input type="checkbox"/> <u>Standardise the process</u> - Screening should focus on early identification using a systematised model of care or pathway that defines the tools to be used, who will conduct screening, the timing and frequency of screening, and pathways for treatment referrals appropriate to the setting (see generic pathway). <input type="checkbox"/> <u>Utilise functionality of electronic medical records (EMR)</u> – embed screening and assessment tools within the EMR and streamline referral processes. <input type="checkbox"/> <u>Select one ward/area to begin screening</u> - undergo iterative cycles of change using a recognised model for implementing change in health services. The Plan, Do, Study, Act model ⁸ is one such model that can be used to adapt and tailor the process accordingly.
Lack of role clarity	<input type="checkbox"/> <u>Communication is key</u> – break down silos by talking to staff and keeping everyone involved. <input type="checkbox"/> <u>Use a recognised framework or model to support implementation</u> – The AACCTT framework ¹⁰ is one such framework that can be used to define roles and responsibilities of multidisciplinary team members. (see AACCTT framework examples)
Inadequate services to refer on to	<input type="checkbox"/> <u>Collect local data</u> - use clinical data such as malnutrition or sarcopenia point prevalence survey data to build business case. <input type="checkbox"/> <u>Utilise a framework</u> - for example team mental model ¹¹ , to develop and refine multidisciplinary services to optimise the success of the team, and importantly clinical and patient-reported outcome and experience measures. <input type="checkbox"/> <u>Connect and network</u> with local services to support transitions of care between your service and other providers.
Limited time and/or resources	<input type="checkbox"/> <u>Prioritise high risk groups</u> - in health services with limited resources prioritise screening of high-risk patient groups. <input type="checkbox"/> <u>Disinvest to reinvest</u> – consider what new opportunities for care might be realized through disinvesting in low value activities and adopting systemized models of care (see Simple toolkit ¹²).
Lack of tools/equipment required to screen and assess	<input type="checkbox"/> <u>Consider using indirect measures</u> - If you don't have access to tools such as BIA device or hand grip dynamometer or BIA consider using indirect measures of muscle mass and function such as calf-circumference, PG-SGA physical assessment or chair stand test. Consider the training requirements of each.
Low motivation for change	<input type="checkbox"/> <u>Build your team</u> - include key players in planning. <input type="checkbox"/> <u>Clinical champions</u> - appoint clinical champions in each clinical area to help build motivation for change. <input type="checkbox"/> <u>Use local data</u> – such as audit or activity data to create motivation for change. <input type="checkbox"/> <u>Engage consumers</u> - in the development and evaluation of multidisciplinary services across the continuum of care. <input type="checkbox"/> <u>Evaluate progress</u> and report results.

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User Guide:

- Form a multidisciplinary implementation team within your current health service / organisation.
- Assess current policies/procedures and resources available at your organisation.
- Use this checklist to identify current barriers and tips to overcome them in your organisation.
- Highlight the areas that are feasible and can be changed in consultation with the team/HOD etc.
- Look at exemplars of evidence-based care in practice for practical guidance.
- Implement selected strategies.
- Evaluate progress.

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