

Need for Data on Physical Disabilities among Nutrition and Dietetics Professionals

Author(s): S.D. Baxter¹, T. Williams², N. Cochran³; ¹University of South Carolina, College of Social Work, ²Tracy's Plate, ³Nutrition Communications Consultant

Learning Outcome: To help prepare to take action to address the unique needs of members of the Academy of Nutrition and Dietetics (Academy) who have physical disabilities, and clients who have physical disabilities, state the number of attendees with physical disabilities at the Food & Nutrition Conference & Expo™ (FNCE®) for each of 2013–2016; limitations of data from FNCE® registration forms; and ideas to obtain data in the future on physical disabilities among nutrition and dietetics professionals (NDP).

Our aim was to report prevalence of physical disabilities among nutrition and dietetics professionals (NDP). The Academy's Strategic Plan identifies "diversity" as a value, defining it as "recognize and respect differences in culture, ethnicity, age, gender, race, creed, religion, sexual orientation, physical ability, politics and socioeconomic characteristics." The Plan's Goal 3 states "Members and prospective members view the Academy as vital to professional success;" Goal 3's outcomes cite "increases in the diversity of" NDP. For the 2015 Compensation & Benefits Survey of the Dietetics Profession, 18% of respondents reported non-employment in a dietetics position, with 3% citing disability/health as a reason. Physical disability data among NDP is not collected currently. FNCE® registration forms inquire about special needs and thus provide the only data on this topic. For example, FNCE® 2016 registration forms asked whether attendees had a disability (hearing [H], mobility [M], visual [V], other [O]) requiring special assistance. As the only data on this topic, we report the special-needs question results from FNCE® 2013–2016 registration forms. For 2013, of 7,890 attendees, 29 indicated disabilities (15 M, 9 H, 2 V, 3 O). For 2014, of 7,967 attendees, 40 indicated disabilities (22 M, 13 H, 2 V, 3 O). For 2015, of 9,183 attendees, 49 indicated disabilities (19 M, 21 H, 6 V, 3 O). For 2016, of 10,436 attendees, 62 indicated disabilities (27 M, 20 H, 8 V, 7 O). FNCE® registration forms exclude non-FNCE® attendees, include duplicates (consecutive FNCE® attendees), and under-represent prevalence. The need is crucial for data on this topic; ideas include a member-wide survey, and asking questions when dues are paid/renewed and on future Compensation & Benefits Surveys.

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How Much Enteral Nutrition Are Our Patients Actually Receiving?

Author(s): R. Defranchi, A. Villar, A. Bordalejo, M.A. Nadal; CEMIC

Learning Outcome: Describe the challenges for identifying discrepancies between prescribed and delivered EN in the critically ill and their causes • Identify parameters to assess and document EN intake • Discuss the use of protocols to avoid unjustified interruptions and the need to adjust EN prescription or infusion rate to prevent underfeeding in the critically ill.

Background: National and international publications have shown incomplete delivery of prescribed enteral nutrition (EN) in critically ill patients. Volume administered of EN in medical records may differ from data saved on feeding pump. Underfeeding may lead to increased infectious complications, length of stay and mortality.

Objectives: To assess the difference between prescribed and delivered EN in critically ill patients and to identify possible causes for discrepancies.

Methods: An observational prospective study of 30 consecutive adults receiving exclusive EN was done in a 9-bed intensive care unit (ICU) and 8-bed coronary care unit (CCU) of an academic hospital in Buenos Aires, Argentina, between November 2016 and February 2017. According to unit protocol, tube feeding was giving continuously via pump with standardized rates and ready to hang formulas. Delivered volume was determined by data recorded in pump.

Results: 146 patient days were included, 84.9% from ICU and 15.1% from CCU. Volume delivered was 76% (SD ± 30.33) of volume prescribed (1090 ± 610 ml vs. 1395 ± 542 ml, $p < 0.001$). Thirty seven percent of patient days received <80% of prescribed volume, being main reasons: unreported (34.5%), procedures (23.6%) and emesis/gastric residue (21.8%). When EN prescriptions were at goal rate (87 patient days) energy and protein adequacy were 78% (SD ± 28.41) and 75.4% (SD ± 30.77), respectively.

Conclusions: one out of three days of EN is inadequate due to feeding interruptions related to the care of critically ill patients.

Implications For Dietetics Practice: Accurate monitoring and documentation of nutritional intake along with the use of protocols with adjusted infusion rates may improve nutrition delivery in critically ill patients.

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Nutritional Status of Adolescents with Type 2 Diabetes and Family History of Diabetes in Mumbai, India

Author(s): J. Madan, S. Singhal, S. Salis; Sir Vithaldas Thackersey College of Home Science SNDT Women's University, Juhu, Mumbai

Learning Outcome: To assess the nutritional status of Adolescents with Type 2 diabetes and family history of Diabetes in Mumbai, India.

Background: Recent data from India indicates increase in the prevalence of Type 2 Diabetes in adolescents. The study attempts to assess the nutritional status of Adolescents with Type 2 diabetes and family history of Diabetes in Mumbai, India.

Methods: A cross section study was conducted on 100 children (50 type 2 diabetic mellitus and at risk : 50 age sex matched controls) with mean age of 15.8±0.28 years, from Mumbai, India. Perinatal maternal food intake, type of delivery, family medical history and present nutrient intake of the children was assessed using standardized tools.

Results: Both diabetic and at risk boys and girls had significantly higher weight for age Z score and BMI for age score as compared to non-diabetic boys and girls ($p < 0.05$). Significantly higher percentage of Type 2 diabetic children had family history of diabetes and other medical complication and were born of C section as compared to non-diabetic children ($p < 0.05$). Diabetic boys had significantly lower energy, protein, carbohydrate, fibre intake as compared to non-diabetic boys. In girls fibre intake differed in both groups ($p < 0.05$). Diabetic boys had significantly lower food variety score and girls had significantly lower dietary diversity score as compared to non-diabetics ($p < 0.05$).

Conclusion: The nutritional state of Type 2 diabetic adolescents and the ones with family history of diabetes reflected higher BMI and poor dietary intake. Prenatal maternal food intake and family history of diabetes are important risk markers and an early intervention is the need of the hour. *Presenting Author- Professor; Department of Food Nutrition and Dietetics, Sir Vithaldas Thackersey College of Home Science, SNDT Women's University, Mumbai. National Vice President Indian Dietetics Association.

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Perioperative Study Completion Predicts Long-term Follow-up with Registered Dietitians after Bariatric Surgery

Author(s): D. Creel¹, L. Schuh¹, B. Logan¹, B. Franz¹, Z. Rodgers²; ¹St. Vincent Bariatrics, ²IUPI

Learning Outcome: Readers will understand factors associated with long-term adherence to RD visits after bariatric surgery.

Background: Patients must maintain healthy eating habits for many years to sustain weight loss and health after bariatric surgery. Registered dietitians (RDs) provide nutrition-related counseling that can be crucial to patients' long-term success. Unfortunately, patients frequently do not attend recommended RD visits after bariatric surgery, especially during the years that weight regain is most likely. The purpose of this study was to determine if participation and completion of a perioperative physical activity study would predict follow-up RD visits for up to 5 years after bariatric surgery.

Methods: Participants (n=148) were separated into two groups—volunteers in a perioperative exercise study (V) versus non-volunteers (NV). NV were matched to V according to age, time of surgery, distance from center and gender. Attendance at postoperative visits (1 month, 3-4 month, 6-8 month, 1-year, 2-year, 3-year, 4-year and 5-year) were compared between V and NV. Comparisons were also made between NV (n=74), dropouts of V (DV; n=36) and completers of V (CV; n=38).

Results: Pearson Chi-Square tests indicated V were more likely to attend 6/8 month, 2-year and 4-year appointments compared to NV. CV were more adherent to postoperative RD visits at 6/8 months and yearly visits up to 5 years after surgery.

Conclusion: Completion of a perioperative physical exercise study (up to 6.5 months after surgery) is a predictor of long-term adherence to RD visits after bariatric surgery. Future studies should assess reasons for this observation such as dispositional factors, provider-patient alliance, and patients' feeling of connectedness to the bariatric center.

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