Clinical Oncology Society of Australia

CHECKLIST TO IDENTIFY AND ADDRESS BARRIERS TO IMPLEMENTATION

Barrier	Enablers
Perceived lack of evidence to support practice	☐ **Refer to key evidence-based guidelines:** - COSA cancer-related malnutrition and sarcopenia position statement[1] - Updated evidence-based practice guidelines for the nutritional management of patients receiving radiation therapy and/or chemotherapy[2] - Evidence based practice guidelines for the nutritional management of adult patients with head and neck cancer[3] - ESPEN guidelines on nutrition in cancer patients[4] - Oncology evidence-based nutrition practice guidelines. Academy of Nutrition and Dietetics[5] - Sarcopenia: revised European consensus on definition and diagnosis[6] - Sarcopenia: A time for action. An SCWD position paper[7] ☐ **Gather key opinion leaders to support implementation** - for example, clinical leaders within the multidisciplinary team.
Not a priority for health service	☐ **Gain leadership buy-in and engagement** - for example, clinical leaders within multidisciplinary team and/or hospital executive. ☐ **Identify local barriers and enablers** - 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). ☐ **Involve the quality department** - Develop local key performance indicators and relevant audit schedule. ☐ **Collect local data** - 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	☐ **Train relevant clinicians** - Utilise freely available training and incorporate into local training packages for clinicians: - COSA cancer-related malnutrition and sarcopenia implementation toolkit - Malnutrition and Sarcopenia in Cancer eLearning program on Cancer Institute NSW eviQ website[8] - Existing videos such as The Importance of Nutrition to Prevent and Treat Low Muscle Mass - YouTube - CanEAT pathway[9] resources freely available at: www.petermac.org/caneatpathway

Lack of local policies, procedures, pathways	☐ **Map local workflows** - 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. ☐ **Care pathways** - Consider use of care pathways to support delivery of optimal patient care (see generic pathway and/or examples given in upper GI exemplar). ☐ **Local governance** - 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. ☐ **Malnutrition governance toolkit**[10] - Utilise this toolkit to support development of local policies/procedures, key performance indicators and other governance supports.
Insufficient pre-existing processes	☐ **Build your team** - Ensure you have good multidisciplinary buy-in and specific strategies to maintain their engagement. Consider clinical champions to help your efforts. ☐ **Standardise the process** - 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). ☐ **Utilise functionality of electronic medical records (EMR)** - Embed screening and assessment tools within the EMR and streamline referral processes. ☐ **Select one ward/area to begin screening** - Undergo iterative cycles of change using a recognised model for implementing change in health services. The Plan, Do, Study, Act model[11] is one such model that can be used to adapt and tailor the process accordingly.
Lack of role clarity	☐ **Communication is key** - Break down silos by talking to staff and keeping everyone involved. ☐ **Use a recognised framework or model to support implementation** - The AACTT framework[12] 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 to	☐ **Collect local data** - Use clinical data such as malnutrition or sarcopenia point prevalence survey data to build business case. ☐ **Utilise a framework** - For example team mental model[13], to develop and refine multidisciplinary services to optimise the success of the team, and importantly clinical and patient-reported outcome and experience measures. Connect and network with local services to support transitions of care between your service and other providers.

Limited time and/or resources	☐ **Prioritise high risk groups** - In health services with limited resources prioritise screening of high-risk patient groups. ☐ **Disinvest to reinvest** – Consider what new opportunities for care might be realised through disinvesting in low value activities and adopting systemised models of care (see Simple toolkit[14]).
Lack of tools/equipment required to screen and assess	☐ **Consider using indirect measures** - If you don't have access to tools such as BIA device or hand grip dynamometer 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	☐ **Build your team** - Include key players in planning. ☐ **Clinical champions** - Appoint clinical champions in each clinical area to help build motivation for change. ☐ **Use local data** – Such as audit or activity data to create motivation for change. ☐ **Engage consumers** - in the development and evaluation of multidisciplinary services across the continuum of care. ☐ **Evaluate progress and report results**

How to use this checklist:

- 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 your team / manager.
- Look at exemplars of evidence-based care in practice for practical guidance.
- Implement selected strategies.
- Evaluate progress.

References:

1. Kiss N, Loeliger J, Findlay M, Isenring E, Baguley BJ, Boltong A, Butler A, Deftereos I, Eisenhuth M, Fraser SF, Fichera R, Griffin H, Hayes S, Jeffery E, Johnson C, Lomma C, van der Meij B, McIntyre C, Nicholls T, Pugliano L, Skinner T, Stewart J, Bauer J. Clinical Oncology Society of Australia: Position statement on cancer-related malnutrition and sarcopenia. Nutr Diet. 2020;77(4):416-425. doi: 10.1111/1747-0080.12631.
2. Isenring E, Zabel R, Bannister M, et al. Updated evidence-based practice guidelines for the nutritional management of patients receiving radiation therapy and/or chemotherapy. Nutr Diet. 2013;70:312-324.
3. Findlay M, Bauer J, Brown T, et al. Evidence based practice guidelines for the nutritional management of adult patients with head and neck cancer. 2011 http://wiki.cancer.org.au/australia/COSA:Head_and_neck_cancer_nutrition_guidelines
4. Arends J, Bachmann P, Baracos V, et al. ESPEN guidelines on nutrition in cancer patients. Clin Nutr. 2017; 36:11-48.
5. Academy of Nutrition and Dietetics. Oncology evidence-based nutrition practice guideline. 2013. http://andevidenceanalysislibrary.com
6. Cruz-Jentoft AJ, Bahat G, Bauer J, et al. Sarcopenia: revised European consensus on definition and diagnosis. Age Ageing. 2018;48:16-31.
7. Bauer J, Morley JE, Schols AMWJ, et al. Sarcopenia: a time for action. An SCWD position paper. J Cachexia Sarcopenia Muscle. 2019;10:956-961.
8. Malnutrition and Sarcopenia in Cancer eLearning modules. eviQEd
9. Loeliger J, Dewar S, Kiss N, Dumbrell J, Elliott A, Kaegi K, Kelaart A, McIntosh R, Swan W, Stewart J. Co-design of a cancer nutrition care pathway by patients, carers, and health professionals: the CanEAT pathway. Support Care Cancer. 2023;31(2):99. doi: 10.1007/s00520-022-07558-6.
10. Malnutrition Governance toolkit. Malnutrition governance toolkit – Victorian Cancer Malnutrition Collaborative
11. Taylor MJ, McNicholas C, Nicolay C, Darzi A, Bell D, Reed JE. Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. BMJ Qual Saf. 2014;23(4):290-8. doi: 10.1136/bmjqs-2013-001862.
12. Presseau J, McCleary N, Lorencatto F, Patey AM, Grimshaw JM, Francis JJ. Action, actor, context, target, time (AACTT): a framework for specifying behaviour. Implement Sci. 2019;14(1):102. doi: 10.1186/s13012-019-0951-x.
13. Klimoski, R., & Mohammed, S. (1994). Team mental model: Construct or metaphor? Journal of Management, 20(2), 403-437.
14. Bell, Jack J., Rushton, A. (2020). The Simple Approach. Scaling, spreading, and sustaining The Systematized, Interdisciplinary Malnutrition Program for impLementation and Evaluation – SIMPLE Phase II.